Hospital Management

OF MICHIGAN
MAR 25 1953
HOSPITAL LIBRARY

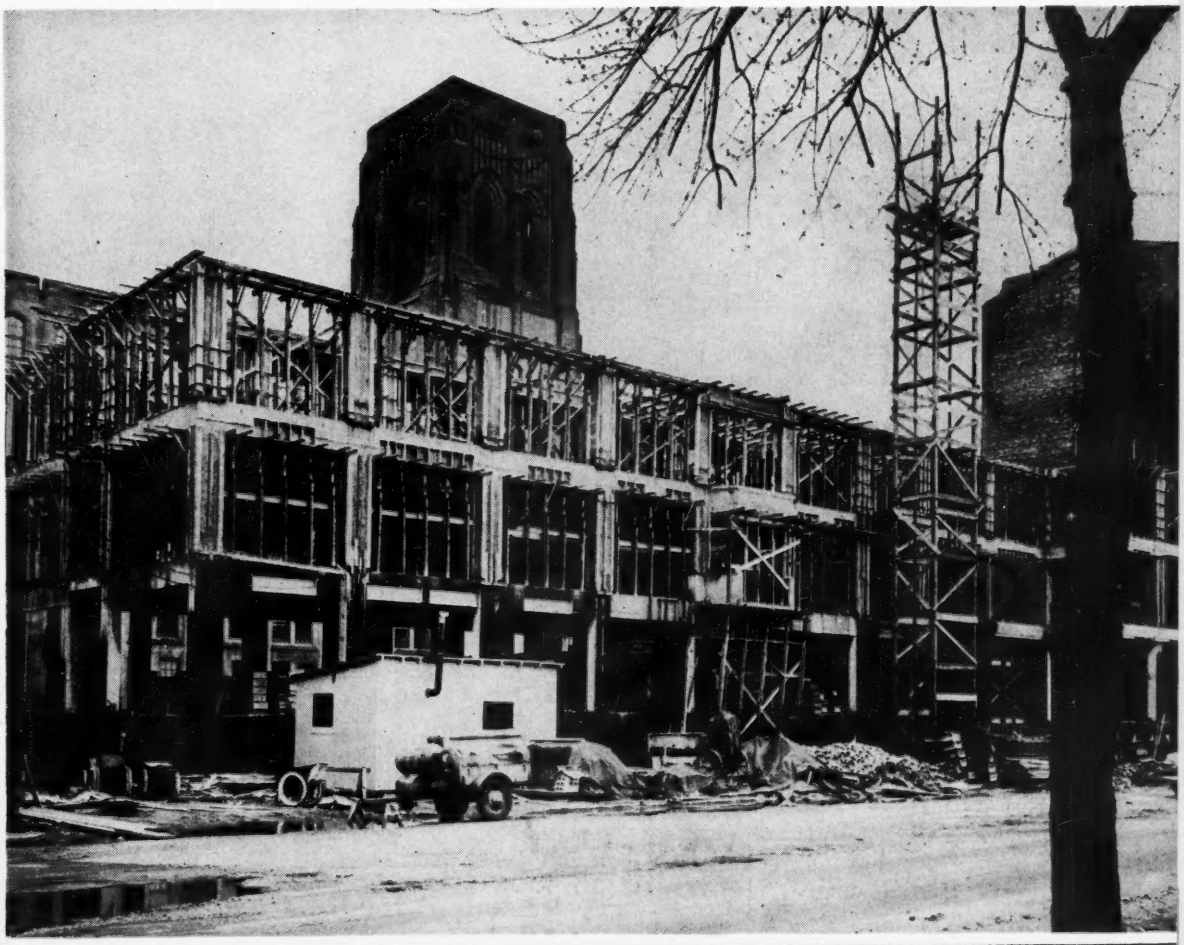
BUILDING ISSUE

. . . Why Hospital Construction Must Be Different Today
. . . What Builders Can Do To Eliminate Noise
. . . Let the Administrator Help Design the Hospital
. . . Alteration Program Designed to Lighten the Work Load

hm

news and technical journal of administration

March • 1953



Classified businesspaper

See page 4

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IMPORTANT NOTICE!

to all 'hm' subscribers, contributors, readers, advertisers . .

As of now (due to the change of publisher announced in the July, 1952 issue), the address of this magazine is:

HOSPITAL MANAGEMENT
105 W. Adams Street
Chicago 3, Illinois

All mail . . subscriptions, manuscripts, photographs, advertising material, etc. . . should be sent to this address.

As others see us

Want to finance a hospital?

Here's a Philadelphia realty firm which has done just that . . . .

■ NEARLY EVERYONE has had some contact with financing, whether for the purchase of a new automobile, a frigidaire or that long-hoped-for house. And mortgage companies let barely a day pass without helping to finance real estate and constructions. However, even so functional a business as a realty firm has room for changes; just recently M & E Realty & Mortgage Co., with offices in the Market Street National Bank Building, opened its doors to a new field in financing, one which will add greatly to its scope.

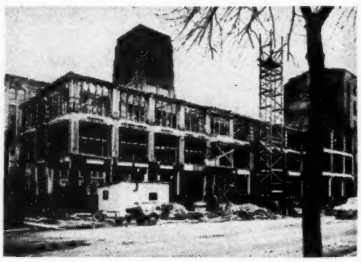
Albert Izen, of the M & E firm, explained that upon settlement of a new doctor-owned hospital on May 15 the first step in the mortgage company's new financing branch would be complete. Financing of the building and its equipment, which cost some $300,000, was a new feather in the cap of M & E which has heretofore worked with brokers, attorneys and individuals, represented insurance companies, trust funds and investors. The loan for the hospital construction was placed with the American National Insurance Co., for which the realty firm is loan correspondent in this area.

Several months ago three physicians who had been connected with the Women's Homeopathic Hospital discussed the idea of building a neighborhood hospital in the Olney section to benefit the residents of that community. The increasing population in the Northeast demanded a hospital, they felt. A factor which hurried the idea into an actuality was the selling of the Homeopathic Hospital, thereby dis-

continued on page 108

Reprinted from the Greater PHILADELPHIA Magazine. May 1952, by permission.

The cover picture



■ TWO HOSPITALS, not one, are under construction here at the University of Chicago Clinics. Nearest the camera is the Charles Gilman Hospital which will be used for research and treatment of contagious and heart diseases. At the right is the west wing of the Clinics group. It will be devoted to research in orthopedics and chronic diseases, including tuberculosis, allergy, arthritis and metabolic disorders. The total cost is $4,500,000. ■

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MEDICAMENTA VERA

Parke, Davis & Company

DETROIT, MICHIGAN

January 1953 . . regional how's business report

REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	707	2,929	12,307	1,255	3,700	8,762	1,730	5,174	9,804	1,414	3,392	8,732
% of OCCUPANCY	48.94	76.57	86.35	58.47	76.52	86.40	75.08	91.51	83.72	71.17	81.72	83.37
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$2.46	$2.47	$2.89	$2.21	$2.30	$2.00	$1.33	$1.90	$2.30	$1.97	$1.81	$2.03
Dietary	3.59	3.02	3.81	3.37	3.34	3.89	2.33	2.74	3.37	2.40	2.99	2.66
Housekeeping	.72	.95	1.23	.87	.97	1.20	.87	.92	.97	.87	.82	1.06
Laundry	.60	.67	.52	.56	.52	.45	.51	.44	.58	.51	.35	.33
Plant Operation	2.53	2.06	2.02	1.96	1.67	1.70	.80	.87	1.24	1.01	.71	1.23
Medical & Surgical	.85	.56	1.11	1.45	1.04	1.05	.82	1.57	1.84	1.07	1.52	1.46
O. R. & Del. Rms.	1.12	1.14	1.34	1.33	.92	1.17	.99	1.35	1.36	.84	1.64	1.42
Pharmacy	.34	1.08	.73	1.08	.76	.81	.79	.97	1.40	2.29	.51	1.50
Nursing	5.96	4.53	4.72	4.99	4.23	5.21	4.11	4.51	4.80	4.94	3.97	4.08
Anesthesia	.79	.28	.54	.39	.48	.47	.28	—	.33	.66	.67	.54
Laboratory	.49	.79	1.27	.76	1.13	1.08	.53	.71	1.15	.63	.47	1.51
X-ray	1.38	1.08	.95	1.25	1.13	.69	.25	.81	.66	.75	.52	1.05
Other special services	.31	.24	.98	.37	.62	1.49	.58	.59	.57	.46	.89	.63
TOTAL EXPENSES	14,682	55,408	283,662	25,662	71,464	187,986	24,448	87,930	206,767	24,767	56,578	173,023
TOTAL CHARGES TO PATIENTS	13,266	62,250	288,982	25,805	77,682	195,776	23,854	90,038	213,353	27,654	62,968	196,986
OPERATING INCOME PER PATIENT DAY	18.76	21.25	23.48	20.56	21.00	22.34	13.79	17.40	21.76	19.56	18.56	22.47
OPERATING EXPENSES PER PATIENT DAY	20.77	18.92	23.05	20.45	19.31	21.45	14.19	16.93	21.06	17.52	16.68	19.18

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,543	3,859	10,543	1,659	4,556	12,361	960	4,459	7,102	2,736	4,891	8,809
% of OCCUPANCY	83.73	85.76	81.37	84.74	84.40	86.12	52.84	81.20	98.28	88.00	75.95	93.88
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$1.55	$2.31	$2.73	$1.60	$1.81	$1.23	$2.46	$2.07	$1.65	$3.51	$3.51	$3.32
Dietary	2.43	2.87	3.45	2.34	3.19	2.52	2.89	3.60	2.88	4.96	3.09	3.12
Housekeeping	.82	.93	1.54	.71	1.00	.95	1.20	1.00	.69	1.08	1.19	1.39
Laundry	.57	.56	1.18	.51	.49	.30	.65	.49	.34	1.16	.57	.44
Plant Operation	1.37	1.53	1.77	1.28	1.30	1.35	1.76	1.00	.74	1.68	1.52	1.48
Medical & Surgical	1.42	1.28	1.88	1.23	1.11	1.41	1.69	.99	2.47	2.29	1.39	1.89
O. R. & Del. Rms.	1.04	1.21	1.26	1.41	1.45	1.14	1.55	.97	1.11	3.36	2.21	2.49
Pharmacy	.89	1.23	.87	3.16	1.11	.85	1.85	1.27	2.35	1.32	.97	.97
Nursing	4.91	5.32	5.88	4.03	4.35	4.79	5.23	5.12	5.90	7.37	7.71	7.59
Anesthesia	.60	.34	.43	—	.26	.51	.62	.51	—	.78	.23	1.39
Laboratory	.71	.97	1.11	.94	.77	1.10	.97	.89	1.19	.82	1.79	2.26
X-ray	1.00	.89	1.19	.98	.62	.59	1.36	.74	.68	1.32	.98	1.02
Other special services	.44	.85	.62	.44	.47	.79	.56	.52	.19	.87	.66	.30
TOTAL EXPENSES	25,218	76,422	258,639	30,742	85,659	214,437	20,551	85,479	148,431	83,557	145,594	243,216
TOTAL CHARGES TO PATIENTS	27,475	83,405	269,012	32,696	90,740	241,004	20,556	95,500	152,368	86,457	133,768	249,823
OPERATING INCOME PER PATIENT DAY	17.81	21.61	25.52	19.71	19.92	19.50	21.41	21.42	21.40	31.60	27.35	28.36
OPERATING EXPENSES PER PATIENT DAY	16.34	19.80	24.53	18.53	18.67	17.35	21.41	19.17	20.90	30.54	28.95	27.81

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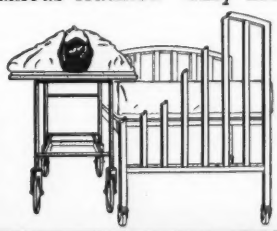

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News from Washington

hm
Hospital Management

▪ Continued improvement in the materials situation is indicated in several recent governmental orders. This is notably so in the Feb. 13 order which removed distribution controls on aluminum, steel and copper.

Allotments of these metals have already been made for both defense and civilian industries for the April-June quarter. But effective Feb. 13 mills are free to accept unrestricted orders once outstanding allotments are taken care of.

▪ Facilities for producing glass tubing used in blood and plasma processing equipment and other lab operations are to be expanded. The plan is to add 38 million pounds to present 226 million pounds.

▪ Vol. V of the 5-Volume report of the Truman Commission on the Health Needs of the Nation was issued early in February, rather out of turn. The explanation for its premature appearance--that is, out of numerical order--was that it had no charts or graphs.

Entitled "The People Speak," this Volume carries 521 pages of testimony from nearly 400 witnesses on the cost of catastrophic illness. These witnesses testified at regional hearings held in Philadelphia, Dallas, Raleigh, Minneapolis, St. Louis, Detroit, Cleveland and San Francisco. The gist of their testimony: long and serious illness is expensive.

▪ The Federal Security Agency as a department with full cabinet rank was brought up by the President at a recent conference with Congressional leaders. The chief question raised was--timing. There also is the necessity for conference with medical and educational groups.

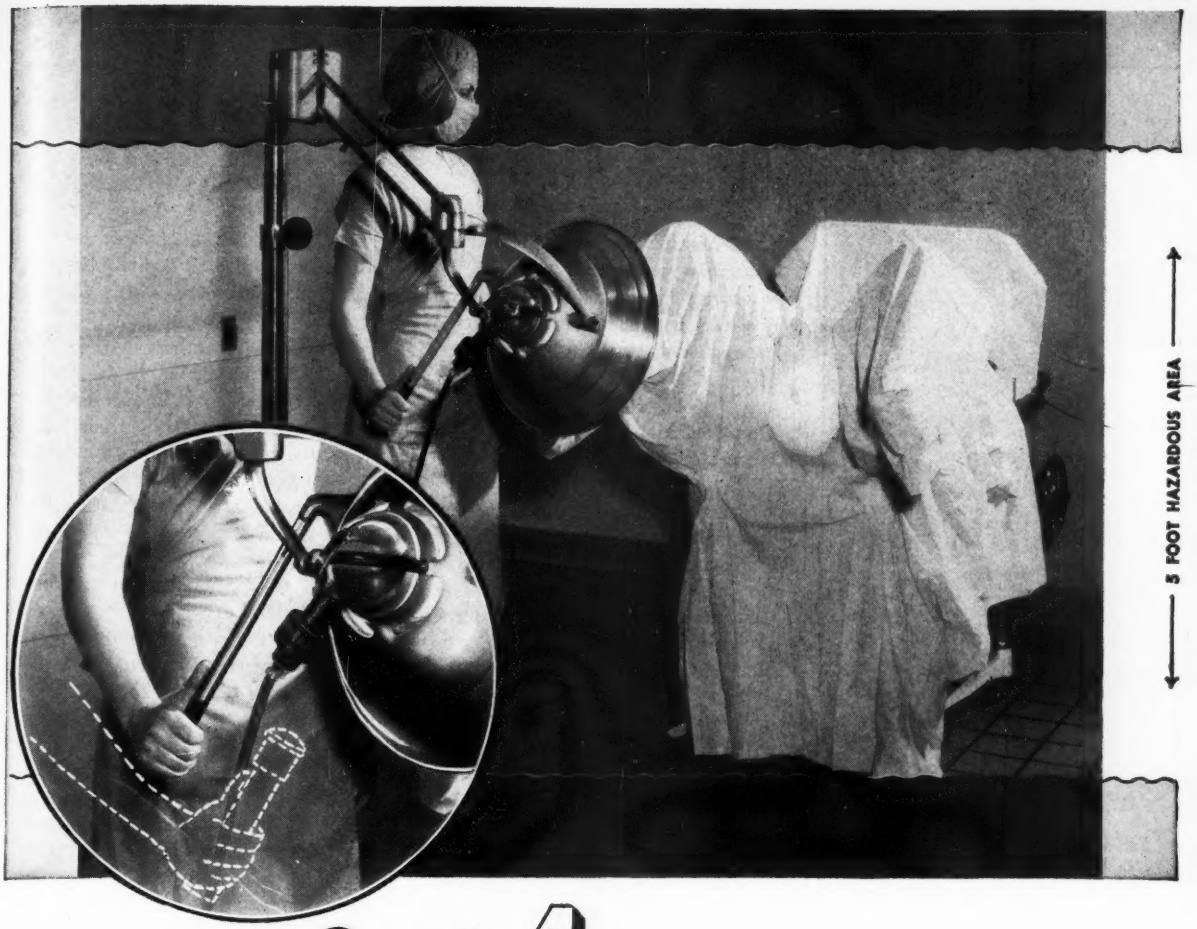
Administrator Hobby, it was recalled, had indicated her belief that the indicated step should be taken. She also removed a major obstacle to it by asserting there would be no socialized medicine during this administration.

A name for the new department--when and if it is created--is Dept. of Health, Welfare and Education, as against the idea of a Dept. of Health and an independent Office of Education.

▪ The proposed expansion of the Social Security set-up to take in virtually all groups not now covered should interest hospital personnel. The President desires prompt action on this. The Ways and Means committee, however, appears definitely opposed to immediate action. They have indicated more study is necessary.

▪ 23 additional projects have been approved since Dec., 1952 under the Hill-Burton program, according to the Jan. 31, 1953 report of the Hospital Facilities Div. of the Public Health Service. Total is now 2,009; cost: $1,590,185.42. This means 97,975 more hospital beds, together with 322 independent health centers.

-- Kenneth C. Crain



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LETTERS

Semi-annual index bound in magazine

■ TO THE EDITOR: Would you kindly send me a 1952 index for HOSPITAL MANAGEMENT.

Mrs. Georgella Fairbanks,
Assistant Superintendent.
The Memorial Hospital,
Worcester, Massachusetts.

■ EDITOR'S NOTE: A semi-annual index is printed in the back of every June and December issue of HOSPITAL MANAGEMENT, listing the essential material printed in the six issues ending with June and December.

Thus, when you bind six copies of HOSPITAL MANAGEMENT, ending with the June or December issue, you have the six months index where it ought to be, in the back of the book and bound in.

It is advisable to bind no more than six issues together. The bound volume then is easy to handle. We also have learned from experience that when you attempt to bind 12 issues, for instance, between covers it isn't very long before the binding of the unwieldy book starts coming apart. You then not only have a size book which is hard to handle but is also soon takes on a disreputable appearance.

There is no doubt that binding of these volumes of HOSPITAL MANAGEMENT is a good way to protect your investment. It also is the most effective way of making an enormous amount of useful information on hospital management constantly available to the entire hospital staff.

Before you bind your copies, though, you must have them complete and in good condition. And that brings up problems.

How is a hospital going to make sure that it has copies complete and in good condition? There are ways.

It is almost certain that so-called "working copies" of HOSPITAL MANAGEMENT, namely, the copies which are sent to various departments, will return in a decrepit condition. Pages will be clipped. Sometimes whole sections will be torn out. Corners of pages will be turned down. The magazines will look like Junior who has spent the afternoon playing football.

Now there is nothing wrong with magazines taking a beating like that. It shows that they have had good, useful material in them. Indeed, the material was so good that the clippers have been busy. And dog ears mean that people marked the page so they could read that page again. Or perhaps it was marked for somebody else to read that article.

But you aren't going to bind magazines which have taken a beating. You want to bind a complete set of magazines in first class condition. So what are you going to do. Here are ways:

1. Many hospital administrators, assistant administrators, department heads, trustees and others will have their own private copies sent to their home addresses. There are many good reasons for this. First and foremost, the magazine can be read at home away from the distractions of the hospital. Articles will suggest future action to be taken and notes can be made and thoughtful consideration given to ideas. These copies can be protected against clipping and otherwise mishandling. They can be kept until six copies or a volume is ready for the binder.

(When we refer to "volume" we are speaking of the volume number just under the "hm" on page 3. You'll note in this issue, for instance, that the reference is to "Vol. 75, No. 3" and also "March 1953." That Volume number changes every six months. The July 1953 issue will be "Vol. 76." The "No. 3" refers to the fact that this is the third issue in this Vol. 75.)

2. Another possibility is to have one subscription sent to someone in the office who is delegated with the responsibility of hiding the copies away until a set is ready for the binder. This person either should be the mousy type adept at avoiding the magazine hunters or the beeg

strong brawny type able to slug it out toe to toe with the magazine hunters and, what's more, lick 'em.

3. As we have said before, there is a third way. That way is to hire a Pinkerton guard to follow the single hospital copy about and defend its sanctity with his life.

(Note from the circulation department: Shucks, it would be cheaper to subscribe for several more copies!)

Practice of free men to permit discussion

■ TO THE EDITOR: I have noticed that you have published in the December 1952 issue of your magazine, under "Letters," my reply to an article by Mr. William S. McNary, which appeared in the November 1951 issue. I sincerely appreciate your devoting space to publishing this answer which has resulted in my having already received favorable comment from persons engaged in the field of hospital management.

It is the practice of free men to permit discussion of both sides of an issue and I should like to compliment you for your action in permitting my views to appear in your publication.

J. W. Crews,
Vice President.
Benefit Association of Railway Employees,
Chicago, Illinois.

■ EDITOR'S NOTE: For further discussion of health insurance see department of Voluntary Health Insurance Plans on page 66.

Reprints

■ TO THE EDITOR: Will you please send us reprints of the article "Budgets aid planning in the hospital" on page 33 of your January issue.

Frances A. Leu,
Secretary.
Albany Hospital,
Albany, New York.

■ TO THE EDITOR: Please forward two reprints of article "How to clean a hospital room" page 136, September issue of your magazine.

John F. Berry,
Assistant Superintendent.
The Springfield Hospital,
Springfield, Massachusetts.

■ TO THE EDITOR: Please send me reprint, if available, of Dr. Ferguson's article (Mailbag), August 1952 issue, in which he discussed progress notes on medical records, discharge summaries and consultations.

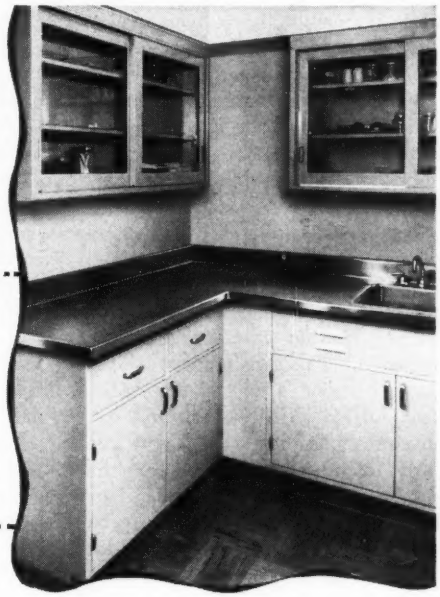
Helen T. Ewing, R.R.L.,
Medical Record Room.
Dobbs Ferry Hospital,
Dobbs Ferry, New York.

■ TO THE EDITOR: Do you have any reprints of the article "New central supply room at Peter Bent Brigham" which appeared in your September 1950 issue of HOSPITAL MANAGEMENT?

Fred C. Roeseler,
Administrative Assistant II
Milwaukee County Asylum,
Milwaukee, Wisconsin.

NEW CONSTRUCTION

OR MODERNIZATION



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"... To Talk of Many Things"

Tell your representative about your hospital and your doctors

by **Frederic M. Wood, Jr.** Administrator • Park Hospital • Mason City, Iowa

■ FOR SOME TIME the Iowa State Medical Society and the Iowa Hospital Association have been urging their members to make every effort to bring their elected representatives into closer contact with and a better understanding of the problems of medical care. The staff of the Park Hospital and Clinic decided to act on this suggestion.

The district representative and senator to the state legislature and the representative to Congress from our district were contacted by telephone. Neither U. S. Senator was available. The legislators were invited to spend a day in the establishment, to go anywhere and ask any questions they wished with regard to our organization or the practice of medicine generally. Response in all cases was courteous and interested. Unfortunately our congressman was returning to Washington before we could set a date. Our state representative and senator accepted.

Formal preparation . . for the visit included a brief outline of our own institution and its operation in order that they might better understand what they saw. A few statistics were developed on the cost of medical care in our institution and how the patient's dollar was spent. It was difficult to decide where to lay the most emphasis or how many topics our guests would like to consider. Their visit provided some information in answer to these questions.

It is my hope that we will arrange another similar visit in the near future. Careful, detailed preparation is vitally important. The topics which deserve the most careful analysis are indicated by the interest shown by the visitors, who are unusually well informed and sympathetic toward the problems of medical practice today.

The visitors arrived about 11 o'clock. An opening statement about the history and outline of operation of our institution was accepted practically without comment.

Next the prepared figures on the cost of hospital operation were presented. Here both men were very much interested and made some careful notes. On a second occasion, more statistics and greater statistical detail on the items of expense which add up to the cost of hospital care were definitely indicated. The direct return to the community of the major share of the hospital dollar seemed to them to be a significant fact.

There is no doubt that question number one in the mind of any person who thinks about medical care is the cost. I feel certain that the figures which were presented to our guests impressed them sympathetically and that this must be the usual response to a careful presentation made with actual figures. It is impossible to overemphasize the importance of careful preparation of this aspect of the hospital's history to any visitor.

A related subject . . of great interest was the over-all picture of available medical care facilities in the United States. Our legislators share the commonly held opinion that there is a severe shortage of hospital beds and doctors in this country at the present time. A careful effort to depict the situation more accurately, not overlooking the flaws and defects of the present coverage, will be rewarded.

The next step was to take the visitors on a complete tour of our small hospital and clinic. Although this did not take a great deal of time, it is probably unnecessary to try and cover the entire institution. Our visitors were not interested in much of the routine. On another occasion the tour could be shortened to points of special interest. Examples of this are x-ray and surgery. Here it is possible to emphasize in very visible terms the high cost of specialized equipment. It was also easy to point out the rapid obsolescence of this equipment because of the constant progress of medical research. This point was interesting and readily comprehensible to our visitors.

In going through the hospital the old comparison of the cost of a hospital room and a hotel room was raised by one of our guests, in a joking fashion. By this time, however, it was relatively easy to point out where the difference lay and why it existed.

The trip through the hospital was followed by a luncheon with all members of the medical staff present. Discussion was general. A list of the high points indicates questions for which it would be well to have carefully considered answers prepared.

In considering these topics . . of discussion, it is also advisable to remember the legislators are about as accurate an indicator of public opinion as a hospital administrator or a doctor is likely to meet. The opinion and arguments expressed by us are unusually significant therefore. It is imperative to satisfy the legislator both as a reasonable individual and as the people's elected representative and to present the viewpoint of the medical and allied professions as strongly as possible.

One of our guests stated categorically that doctors' fees are exorbitant. One of the staffmen remarked

continued on page 76

Wounds sutured with smaller sizes of D & G surgical gut on Atraumatic needles have less trauma and heal faster and more evenly.

faster wound healing

Patients move about more freely after their operations and are out of the hospital sooner when their wounds have been closed with a minimum of trauma. Davis & Geck offers two modern aids to faster and more even healing:

1. Davis & Geck "timed-absorption" surgical gut—in small sizes
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Davis & Geck surgical gut sutures may be used in smaller sizes than might be expected because *diameter for diameter* the tensile strength is unexcelled by any other brand. By a unique process of control, these "timed-absorption" sutures offer maximum resistance to digestion during the early days when the wound is weakest. After healing is under way, digestion is more rapid until completed. Smaller suture sizes permit closer approximation and provoke less trauma. The patient's convalescence is smoother.

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In suturing with Atraumatic needles there is less tissue trauma, faster and more even healing. The D & G Atraumatic needle is joined to its suture smoothly. Needle and suture are about the same diameter. No big eye and double strand of suture are dragged through the tissue. Sutures on Atraumatic needles are economical, too. Surgery is easier and faster, needles are always sharp, *no time is lost while the nurse threads needles.*

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THE HOSPITAL CALENDAR

List Your Meetings

As soon as the dates for the next succeeding meeting of an organization have been determined an official should forward those dates at once to Editor, Hospital Management, 105 W. Adams St., Chicago 3, Ill. to insure appearance here.

March

20-21 . . Georgia Hospital Association, Atlanta-Biltmore Hotel, Atlanta, Ga.

23-25 . . New England Hospital Assembly, Statler Hotel, Boston, Mass.

24-26 . . Kentucky Hospital Association, Seelbach Hotel, Louisville, Ky. Executive secretary, Elizabeth D. Simmerman, Henry Clay Hotel, Louisville 2, Ky.

April

6-7 . . Louisiana Hospital Association, Jung Hotel, New Orleans, La.

6-9 . . Ohio Hospital Association, Netherland Plaza Hotel, Cincinnati. Harry C. Eader, Executive secretary, Room 414, 55 E. State St., Cleveland 15, O.

8 . . Mid-year meeting, Washington State Hospital Association, Davenport Hotel, Spokane, Wash.

8-10 . . Southeastern Hospital Conference, Jung Hotel, New Orleans, La. Secretary-treasurer, D. O. McClusky, Jr., Druid City Hospital, Tuscaloosa, Ala.

15-17 . . Midwest Hospital Association, Municipal Auditorium, Kansas City, Mo. Executive secretary, Mrs. Anne Walker, 933 McGee Street, Kansas City 6, Mo.

27-30 . . Association of Western Hospitals, Utah Hotel, Salt Lake City, Utah. Executive secretary, Melvin C. Scheflin, Association of Western Hospitals, 26 O'Farrell Street, San Francisco 8, Calif.

26-May 1 . . American Surgical Trade Association, Edgewater Gulf Hotel, Edgewater Park, Miss.

30-May 2 . . Mid-year meeting, American Osteopathic Hospital Association board of trustees, Hotel Sheraton, Chicago, Ill.

May

1-8 . . Carolinas - Virginias Hospital Conference, Cruise to Bermuda, S. S. Queen of Bermuda, Norfolk, Va. Executive secretary, Sample B. Forbus, director, Watts Hospital, Durham, N.C.

4-6 . . Tri-State Hospital Assembly, Palmer House, Chicago, Ill. Executive secretary, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville 11, Ind.

4-7 . . National Association for Practical Nurse Education, Hotel New Yorker, New York City.

7-9 . . British Institute of Hospital Administrators, Hastings, England.

8-10 . . Tennessee Hospital Association, Andrew Jackson Hotel, Nashville, Tenn.

12-14 . . Texas Hospital Association, Buccaneer Hotel, Galveston, Texas. Executive secretary, Ruth Barnhart, 2208 Main St., Dallas 1, Texas.

13-15 . . Upper Mid-West Hospital Conference, Minneapolis, Minn. Executive secretary, Glen Taylor, Upper Midwest Hospital Conference, 410 Church St., S.E., Minneapolis 14, Minn.

18-22 . . Medical Records' Librarians Training School, American Osteopathic Hospital Association, Detroit Osteopathic Hospital, Detroit, Mich.

20-22 . . Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N. J. Included will be the state meetings of the Hospital Associations of New York, Pennsylvania and New Jersey. Executive director, J. Harold Johnston, New Jersey Hospital Association, Trenton, N. J.

22 . . Maryland-District of Columbia-Delaware Hospital Association, Wicomico Hotel, Salisbury, Maryland.

25-28 . . Catholic Hospital Association, Municipal Auditorium, Kansas City, Mo. Executive secretary, M. R. Kneifl, 1438 South Grand Boulevard, St. Louis 1, Mo.

25-30 . . International Hospital Congress, London, England.

June

5 . . North Carolina Hospital Association, Asheville, N.C.

15-19 . . American Physical Therapy Association, Baker Hotel, Dallas, Texas.

22-24 . . Quebec Hospital Committee, Auditorium and Arena, College St. Laurent, Montreal. Executive secretary, Roland Levert, 325 St. Catherine Rd., Montreal 8, P.Q.

22-26 . . National League for Nursing, Hotel Statler, Cleveland, O.

28-July 3 . . American Society of X-ray Technicians and Canadian Society of Radiological Technicians, Royal York Hotel, Toronto, Ont.

August

5-9 . . American Association of Medical Record Librarians, Palace Hotel, San Francisco, Calif.

24-28 . . Western Institute for Hospital Administrators, American College of Hospital Administrators, Stanford University, Palo Alto, Calif.

25-27 . . Gerontological Society, Mark Hopkins Hotel, San Francisco, Calif.

25-28 . . American Dietetic Association, Shrine Civic Auditorium and Hotel Statler, Los Angeles, Calif.

29-30 . . American College of Hospital Administrators, San Francisco, Calif.

31-Sept. 3 . . American Hospital Association, Convention Hall, San Francisco, Calif.

October

18-21 . . American Osteopathic Hospital Association, Statler Hotel, Los Angeles, Calif.

November

9-10 . . Maryland-District of Columbia-Delaware Hospital Association, Lord Baltimore Hotel, Baltimore, Md.

Why Hospital Construction Must Be Different Today

New hospitals must adjust structure to function, because only a functional master plan will guarantee better health care

By E. M. BLUESTONE, M.D.
President, American Association of Hospital Consultants

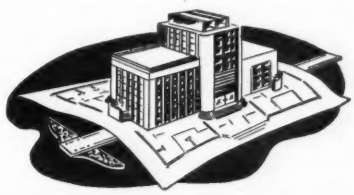
■ THE MODERN HOSPITAL, with its superior facilities . . the best in any community . . is grappling with a number of serious problems these days under the pressures of clinical medicine, laboratory medicine and social medicine. These pressures are brushing aside the resistances and dragging the hospital out of its time-worn shell into the waiting world beyond. Successful experiments are being conducted with new and more equitable ways of adjusting supply to demand in medical care and the hospital is finding that it must extend itself in order to maintain its position in the vanguard.

"Do we need more beds in our hospitals?" is a question which is on the minds of many trustees and administrators, though not as strongly as in the past decade when expansion in this direction was almost a war-cry in the pre-home care era. "Are we making the best use of those that we have?" is a question which no thoughtful medical-care worker can avoid and we thus have what might be called a bed-audit.

"Where shall be seek additional beds, if they are needed, without paying unprecedented prices for their establishment and maintenance?" is a question which occupies the minds of trustees as well as social workers, who now have the advantage of answers already known. Another set of questions relate to (a) the preventive aspects of hospital work; (b) the educational aspects of hospital work; and (c) the relation of space to bed in hospital service.

• **Preventive aspects . .** How shall these be realized in actual practice? Specifically, how shall the hospital and health department collaborate, structurally and functionally, so that all the benefits of each can be immediately available to the other?

• **The educational aspects . .** What, for example, is the effect of distance . . apart from high scientific caliber (teachers and teaching material) . . on the relationship between the medical school and all hospitals in its area? If, as I have repeatedly maintained, every bed in every hospital, no matter where it is located or by whom occupied, is



Building Issue

potentially a teaching bed and potentially a research bed, how shall the medical school make practical use of such opportunities and how shall the hospital prepare and offer its wares to the medical school? The stimulus provided by medical school collaboration is precious. Perhaps, for this reason, it is carefully rationed to hungry hospitals, compelling them to deserve such a boon in every way.

• **Relation of space to bed . .** We need more space per bed than ever before. How shall we provide it in the existing hospital and . . what is less difficult for the architect, if not for the trustee . . in the hospital which is in contemplation or on the drawing boards? What are the limits of laboratory service, if any? What are the demands on the hospital, in cubage, of an extramural hospital program? What space provisions shall we make for the new teachings of social medicine?

• **Noblesse oblige? . .** How can hospitals help each other more effectively? How can they cooperate more productively with related organizations in the overlapping area of their activities? Also, how can hospitals in the more fortunate areas help their weaker brothers (weak in facilities) in the less fortunate areas? How can a regional plan of hospitalization be realized without doing damage to the identity, traditions and amour propre of the hospitals entering into such a plan. How shall the ancient principle of noblesse oblige be carried out by the larger hospitals in relation to the smaller ones?

We have known for the better part of this century that inpatient and outpatient departments must be treated as integrated activities, inseparable from each other functionally as well as structurally. What has prevented this requirement from spreading more rapidly and finding more universal acceptance? Special hospitals are gradually disappearing as such. They are transferring their clientele as well as their good-will to general hospitals, in response to the advancing interaction of all of the medical and surgical specialties.

What about the independent hospital for chronic diseases? Will the "acute" general hospitals henceforth retain patients as long as they need hospitalization and resort to home-care programs for those who do not, or will they continue to transfer their undesirables to the "hospital" for chronic diseases?

As the science of medicine advances and funds for maintenance from all sources increase, there is less reason for transfer. We have a right, therefore, to anticipate the disappearance of the independent hospital for chronic diseases through the absorption of its activities by the general hospital and by the patient's own home (subsidized, if necessary) or an adequate substitute for his home.

THE MEDICAL AUDIT

The audit, friends, will bring you rest
If you are troubled with your staff;
The grain will always stand the test
While winds will blow away the chaff.

—E. M. BLUESTONE, M.D.

• **More laboratories . .** New specialties have come into practical use in medical care and the planner must make provision for them. Dentistry, physical medicine, (from physical and occupational therapy through rehabilitation) and podiatry, immediately come to mind as useful adjuvants in the medical care of the total patient. New laboratories must be provided to keep pace with medical and surgical progress.

What about the patient suffering from tuberculosis, and the patient suffering from mental disease? In principle we agree on their inclusion in the work of the general hospital. How shall we arrange for it in practice? Have we the courage to experiment with demonstration projects which will prove that our principles can be carried out in practice and how shall we sell this idea to government and to philanthropy for the purpose of obtaining the necessary financial support for such studies?

The material things and the mechanical things which go into the management of a hospital trouble us less because these are being placed in our hands, for the asking, by a multiplicity of non-medical agencies experimenting successfully elsewhere in the world of engineering finance and economics. We are far more concerned in our hospitals with the social and medical planning aspects. Some fear to contemplate these because of their newness; others decline to consider on the theory that the conduct of the traditional hospital is trouble enough in itself without looking for more elsewhere.

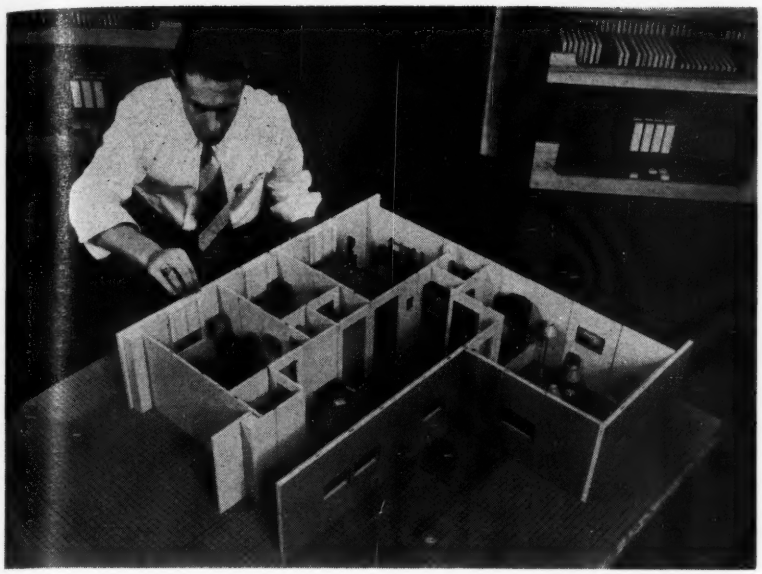
Never before in hospital history has it been more imperative for consultant, trustee, administrator, social worker, and architect, to work out their problems together. *Never before has a functional master-plan for every hospital been more urgently needed.* Never before has an architect been called upon to interpret this plan in terms of construction that will permit the walls to melt away . . or be set up anew to better advantage . . when service must be provided which is more highly differentiated than the service which characterized the hospital in the first place.

The chances are that the future hospital will have to increase its service space to take care of a far greater number of patients outside of its walls than inside of them. How will this be done? What is the easiest way of readjusting structure to function? We hope that the reader will find some of the answers in the articles which follow. ■

Estimated Physical Volume of Building Announced

In accordance with contract records for 37 eastern states, the F. W. Dodge Corporation estimates Hospital and Institutional building for 1953 at 30 million square feet. This compares with Dodge's estimate of 25 million square feet for 1952.

The estimated volume for other building classifications are as follows: Commercial, 95 million square feet; manufacturing, 100 million; educational and science, 105 million; public, 14 million; religious, 15 million; social and recreational, 18 million.



EXPENSIVE EQUIPMENT INSTALLATION requires precise planning, so. .

Let the Administrator Help Design the Hospital

This means he must be on the job BEFORE the contract is let to obviate errors in planning

by REED B. HOGAN

Administrator, Coahoma County Hospital, Clarksdale, Miss.

■ THE RECENT and continuing nationwide hospital construction programs have posed many varied problems for the general public and particularly for local hospital boards of trustees.

Of all the problems that confront hospital operating officials, one is seldom mentionad and probably is the most neglected of all: Selection of an administrator or a superintendent by governing boards of newly constructed hospitals to administer hospital affairs. This is a problem that effects all levels of activity for frequently state and national officials are asked for advice on the selection. The selection of an administrator is a problem in itself. The first actual problem in regard to the administrator is *when* to employ one.

How do governing boards go about hiring an administrator? Some employ him to begin work only a few weeks before the admission of the first patient; others prefer that he be on the job before the contract for the construction of the hospital has been awarded. This paper is in support of the latter practice. Cited below are a few cases which support this viewpoint.

1. Case History; Trustees Plan Everything

In one county hospital the board of trustees advised the architects, who were planning their first hospital, in regard to physical arrangements of the building; the physicians were not even consulted. Before even considering the employment of an administrator, the board of trustees selected all the equipment and most of the supplies on the advice of a small surgical supply company which had a very questionable reputation. A large number of the hospital staff were employed by the board without the slightest indication of good personnel practices. The administrator was finally employed after all the real organization was completed.

The first question that might arise is: Why would an administrator accept such a position in the first place? The administrator selected was not truly an administrator; he was a local politician who managed to retire on the fair salary paid the administrator. It is not likely that he will ever be considered as an administrator by the vast majority of hospitals because most hospitals have competent, trained administrators.

• **50% Above List . .** This administrator was faced with terrific problems. Approximately one-third of the beds planned and installed were actually needed. The hospital was elaborately equipped with items that would not be included in any well-planned hospital. In some cases prices paid for equipment were as high as 50 per cent above list price. Some very expensive equipment installed will never be used because of local circumstances.

Parts of the hospital were air conditioned where neither the employees nor the public were actually spending even a small percentage of their time. The laundry was in a semi-basement without even a ventilating fan for a window. Operating rooms, delivery rooms, and emergency rooms were widely separated from the sterilizing rooms which necessitated extra working hours and personnel; surgery rooms were widely separated from the wing which surgical patients were to occupy.

There were many more examples of bad planning. The personnel employed before the administrator arrived were employed on the basis of friendship to certain people and according to political expediency. It is useless to point out that if a trained administrator had been employed during the blue-print stage of the hospital planning, several thousands of dollars would have been saved in addition to his salary; the community would have had a better hospital; the hospital would not have had to open under the shadow of a political football; em-

ployees unwisely employed by the board would not have been uprooted from their former jobs for what turned out to be only a temporary affair; better equipment or more suitable equipment would have been purchased; working conditions would have been much better; fewer beds would probably have been obtained; and the area to be served would have had a hospital, properly planned, without waste of public money.

It is recognized that the condition outlined above resulted because a Board of Trustees was in control. Furthermore the board was dominated by persons who did not have the best interests of the community at heart. It is also obvious that the Board of Trustees was not advised by persons who were in a position to give proper counsel.

2. Why Faulty Planning Is Costly

One hospital was so poorly planned that space was not allowed for an emergency room or space to care for emergency cases was not provided. Vital equipment was not installed. Some equipment, good equipment for some hospitals, had to be exchanged for equipment suitable for that hospital. Office space was not provided in any degree. Then the board of trustees employed a competent administrator. In a very short time he corrected most of the mistakes but it was at great expense to the unit of government involved. If the administrator now employed by the hospital had been employed a year before the date he started to work, thousands of dollars would have been saved that could now be used advantageously. This board of trustees is one of the best, but it made a tragic error in waiting too long to employ the administrator.

The board of trustees of a Hill-Burton County hospital thought they were playing safe and even ran the risk of public criticism by employing an administrator six months before the hospital was due to be completed. On arrival at the new hospital, the administrator found that several thousands of dollars was spent for the inclusion of a purely architectural beauty spot that they knew would be removed the first time an addition to the hospital was constructed. The fact is it is now gone.

One relatively expensive piece of equipment was installed with a water leak in it. This leak could not be corrected satisfactorily after installation. After the administrator complained, the supplier of that piece of equipment came up with this retort: Place a bucket under the leak to catch the water.

It was too late to make corrections without cost to the hospital. Equipment was installed; later it had to be changed at great cost because essential accessories to that equipment were not installed at the same time the principle piece was installed.

Some windows could not be opened because of outside obstructions; obstructions were a part of the main building. Equipment not used in any hospital in that area was installed and could not be used or exchanged. Many needed facilities were completely ignored. Again, this hospital had a good Board of Trustees; but the board had waited too long to employ an administrator. In this case the hospital could have paid the administrator for at least five years and still not have lost any money. The hospital would have been better.

• **Exceptions Cost Money** . . A large hospital in a prosperous area employed the administrator to begin work approximately three months before the hospital was due to open. This administrator inherited a board of trustees from the old hospital. Prior to opening the new hospital and the selection of an administrator, arrangements had been made to transfer the entire staff from the old hospital to the new hospital. The hospital was well-planned with few exceptions, but the exceptions were expensive when the cost of operation is regarded. In transferring the staff with the same board policies, rules, and regulations, the administrator was severely handicapped for several months. This administrator is well-trained and is doing an excellent job of administration under the circumstances; changes are gradually being made that will make a tremendous difference in the operation of the hospital. If the administrator had been employed during the early days of construction, most of the prior arrangements made could have been avoided with enormous savings to the local unit of government. These savings could have been made, not only in construction, but in management of personnel affairs and in general administration during the first few months of operation. The early stages of the hospital operation were very rugged; they could have been practically ideal at that hospital.

An administrator was recently employed by a hospital to be opened in approximately six months. He found thousands of dollars worth of equipment already installed that was useless to the hospital from any standpoint. Elaborate and extravagant equipment could easily have been replaced by less costly equipment that would be as well-suited for that hospital from any viewpoint. Mistakes were made in many places that cost the taxpayer dearly; mistakes were made that the administrator could have avoided. The board of trustees at this hospital is as good as the best. However, their advice on employing an administrator was conflicting. Although they thought they were playing safe in regard to timing, they employed the administrator several months too late.

• **One Hospital For Two Doctors** . . One hospital was constructed in a rural area with a small population in the area as whole. There were only two doctors in the community; one was semi-retired. There was no need for the hospital in the first place, but it so happens that a very influential person was born there; therefore, the hospital was constructed regardless of need. An administrator was employed a few months before the hospital was to open. When he reported to the hospital, he found many of the typical mistakes. Even in such a case as this, the administrator would have made substantial savings if he had been there early enough to help plan the entire hospital program.

Many other cases such as the

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CORRIDOR CEILING INSULATION is sound deadener, highly important because corridors otherwise act as huge speaking tubes.

What Builders Can Do To Eliminate Noise

The advantages of sound conditioning are not limited to newer buildings

The importance of the effect of noise on the individual is probably best set forth by a noted medical man in his report to the American Medical Association several years ago where in his conclusion he says, "Noise may lead to deafness, but of all the hazards, the effect upon the nervous system is the most serious . . his ability to work, his mental capacities, and his personality. Anything which injures the nervous system is dangerous to the welfare of the individual and to society in general. Noise lowers all our faculties, dulls our mental processes, and reduces the precision of our actions, drags personality to a low level. It makes us irritable, pessimistic and grumpy. We become unpleasant to the people we live with."

Of particular significance to this group is the fact that he was speaking of normal people in normal health. The late Dr. Irving S. Cutter, in a talk before the Greater Chicago Noise Reduction Council, pointed out that the hospital patient was anything but normal in his reactions and consequently the effects

NURSE OR PATIENT . . they never get used to noise.

of noise are magnified many times in the case of folks in ill health.

A brief review of the literature covering investigations in this field will show that noise is known to affect the actions of the stomach . . the muscles . . that it increases brain pressure . . causes changes in the electrical resistance of the skin . . and probably most important, generates a fear reaction.

There is a general belief in some quarters that people, even those who are ill, can get used to noise. Dr. Carey P. McCord points out in one of his papers in the Journal of the American Medical Association that such is not the case. He states that the fact that symptoms are not always apparent does not mean that the effects are not present. Dr. Cutter explained this same point by stating that his observations over 25 years indicated that certain people can condition themselves to noise but they never get "used" to it. Experience during the intensive drive for great industrial production during the war days with employees who had never before worked in factories, bore out Dr. Cutter's observation that a large portion of our people can never condition themselves to noises of high intensity.

• **What is noise? . .** Dealing with noise it is first necessary to understand just what it is. The term "noise" seems to have a different meaning for each individual. To one, it will bring up visions of a pneumatic hammer operating in the street, to another a midnight train that rumbles by during precious hours of sleep, to others it will mean honking automobiles, irritating radios, etc. In seeking a term that would be equally meaningful to all, the Acoustical Materials Association in conjunction with the American Standards Association adopted some years ago a term "unwanted sound." Even the quickest analysis will show that while this term is a homely one it is indeed accurate. Sounds that may be welcome and enjoyable in the middle of the afternoon can be irritating noise late in the evening or during the middle of the night.

In practical life it seems that no one ever is conscious of making noise; we never mind our own racket. It is the other fellow's noise that bothers us.

Since noise is sound, in order to deal with it effectively we must know a little about sound. As most of you will recall from your school days, knowledge of sound itself is one of the oldest sciences. However, it has only been during recent years that we have learned about the behavior of sound within rooms. The science of architectural acoustics was really born about the turn of this century through the investigations made at Harvard University by Dr. Wallace C. Sabine.

• **Noise control . .** In dealing with problems of noise . . or how to control sound . . we approach the problem in three ways:

1. We can diminish the sound at its source.
2. In some instances we can isolate it.
3. Through the use of acoustical materials we can absorb it and cause it to die out quickly within buildings.

Modern designers and builders of hospitals are doing all they can today to eliminate sound at its source by installing quietly operating elevator doors, using resilient floor coverings, installing noiseless wall switches, using noiseless plumbing fixtures.

Hospital administrators are eliminating noise by using rubber tire service carts, using rubber coated trays in utility rooms, applying silent casters to all furniture and in some instances carrying out the very practical policy of insisting that all employees wear rubber heels while at work.

A great deal is being done to eliminate noise in the hospital by architects who are specializing in hospital buildings. By locating service areas such as kitchens, cafeterias, utility rooms, etc., as far as possible from patients' rooms much of the disturbance common to older hospital buildings is cut down to a minimum.

• **What's a noisy building? . .** Unfortunately the necessary activities in a busy hospital generates a certain amount of noise. As a constant warning to employees and visitors, "Quiet, Please" signs are used generously in most hospitals. However, if you have an exceptionally noisy building, it is impossible for any one to be "quiet" in that building. By a noisy building, I mean one that through its reverberant condition tends to sustain all sounds by multiple reflection from wall to ceiling to floor and back again many times. The extensive use of exceedingly hard floors, glazed tile, etc., with no provision for counteracting sound absorption, makes many older hospitals extremely noisy.

• **Acoustical materials . .** These were first designed for use in auditoriums, classrooms and lecture halls where it was necessary to control the prolongation of sound in order to have satisfactory hearing conditions. The first use of these materials for the suppression of noise is generally credited to a judge in Cleveland who reasoned that if the absorption of unwanted and unnecessary reflected sound would improve hearing conditions it would also be effective in suppressing general court room noise and disturbances. This installation was made about 1913. Since that time the use of acoustical materials for sound conditioning rooms and buildings against annoying noise has grown to tremendous proportions in ratio to the use of such materials for auditorium and lecture room use. Your institutions, the hospitals, represent as a group the third largest users of sound conditioning.

The advantages of sound conditioning is not limited to newer buildings. Fortunately it is possible with modern materials to treat effectively all older buildings.

The use of sound conditioning in hospitals began by the installation of acoustical treatment in obviously noisy places such as kitchens, utility rooms, nurses stations, etc. During the past 15 years experience has shown that for the benefit of the building as a whole, the corridors unquestionably rank first in importance for treatment. The reason

ACOUSTICAL TILE ceiling, installed in the lobby of the Truett Memorial Hospital, Dallas, Texas, is practical as well as attractive.

for this is easily seen. Corridors in any hospital, unless sound conditioned, act as a huge speaking tubes that distribute the sounds generated in the corridors and the sounds that enter the corridors from other areas through the entire building. Sound waves flow around corners easily. Once the sound or noise enters the corridor it continues to travel the length of that corridor, spilling through all doorways until it is dissipated. In the case of corridors having hard floors, walls and ceilings the sound is reflected so many times it frequently has the aspect of actually being amplified.

• **Ceiling most important . .** Applying an acoustical material with adequate sound absorption to the ceiling area only is usually sufficient to cause average corridor noises to die out quickly . . and to be cut off before they travel very far.

The effects of such treatment are particularly noticeable where nurse stations are located, as they usually are, at the corridor conjunction. The necessary conversation at these stations and the little noises generated from other necessary work are confined to the immediate vicinity of the station.

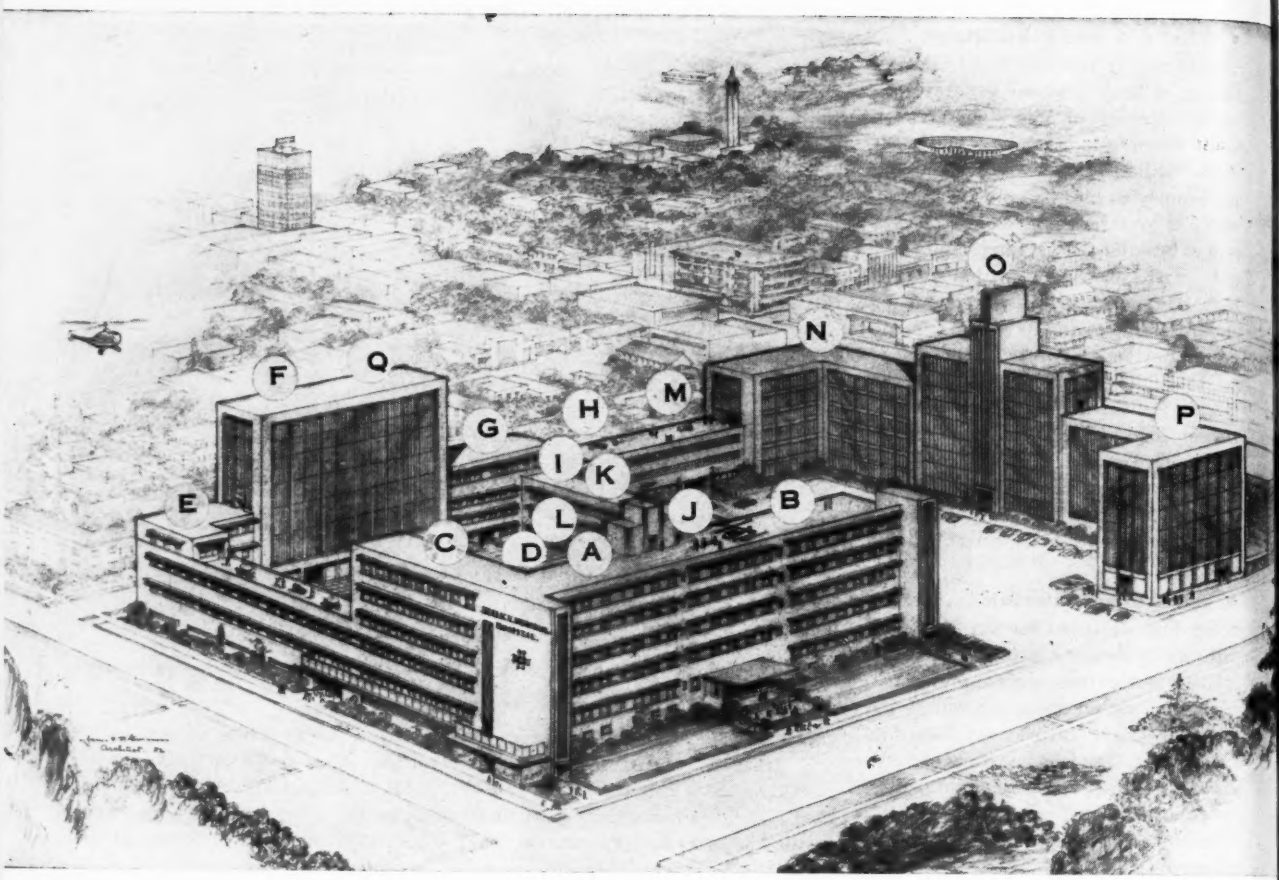
Other than the very obviously noisy areas, it is rather difficult to make a list by order of importance of the other locations where acoustical treatment could be considered a "must." The best answers to any questions are always found in experience.

The only room in the hospital where there seems to be any reasonable amount of controversy as to whether it should be sound conditioned is the private patient's room. Early acousticians felt that because the bed and bedding provide a considerable amount of absorption, treatment here was unnecessary. As hospitals have gained experience the pendulum seems to be swinging in the direction of treating these rooms where it is possible to do so. In fact, Charles F. Neergaard, noted hospital consultant, recommends sound conditioning throughout.

Early types of acoustical treatment, which were largely made up of some combination of hair felt with a covering membrane of some type of cloth, usually muslin, were of course impractical for a hospital where sanitation is a problem.

• **Prefabricated materials . .** Development of a prefabricated

continued on page 120



Berkeley, Calif. Envisions New Medical

"In the past decade there have been numerous and increasing evidences of recognition of the merging of the interests of the community hospital with other community functions," says Dr. Edward S. Rogers, M.P.H.

No better example of this integration could be found than the Herrick Memorial Hospital. Here's why:

■ ALTERATIONS AND ADDITIONS will turn Herrick Memorial Hospital into a comprehensive medical center that will be as modern as its heliport (roof landing space for helicopter ambulances).

It means a giant stride forward in the prevention, diagnosis and treatment of disease for all people, regardless of race, color, creed or ability to pay.

In brief, here are the projected changes, which are materialized in the drawing above and identified on the opposite page:

■ Erection of the William Walter Reich Memorial Building, for which over $300,000 has been pledged, and which already has been blueprinted. It will house Herrick Hospital Clinics on the ground floor, a pediatric unit on the second and allow for obstetrics expansion, including rooming-in facilities on the third floor, cancer research on the fourth, medical nursing on the fifth and psychiatric department on the sixth story.

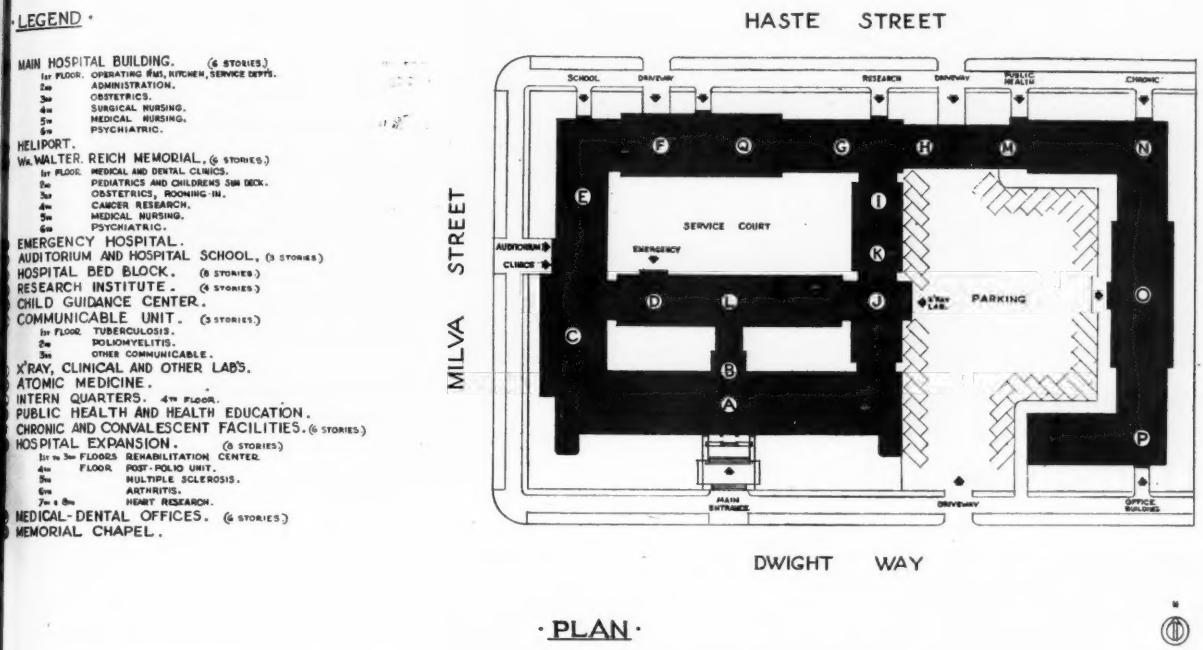
■ Erection of an eight-story hospital bed block .

■ Two additional stories atop the present 4-story main hospital building . . with 60 psychiatric beds on the top floor.

■ A six-story building for chronic and convalescent facilities.

■ An eight-story hospital expansion building, with three floors de-

Blueprint for a long range program expected to be 20 years in the making shows civic spirit of Berkeley, California and adjoining communities. The story of a dream to be realized . .



Center Around Herrick Memorial

voted to a rehabilitation center, and other floors for post-polio care, multiple sclerosis, arthritis and heart research.

- An auditorium seating 250 on the ground floor, with the Herrick School of Hospital Arts on two upper floors.
- A four-story research institute and Child Guidance Center.
- X-ray, clinical and other laboratories, headquarters for atomic medicine, Public Health Center and health education.

Integration of the hospital into the community life . . and purview over these expansion projects . . are under the leadership of A. E. Maffly, administrator of Herrick Memorial.

Dr. Edward S. Rogers, M.P.H., professor of public health and medical administration at the University of California, has commented, "Were there any ready means of comparing what [has already been] accomplished with the work of other hospitals, I think that, in terms of size, the Herrick Memorial Hospital and Clinics would rank among the foremost in this country."

Dr. Rogers pointed out that the Herrick Hospital paid staff serves part-pay patients through the clinics just as it does the full-pay patient, except that the attending medical staff contributes its time, without any compensation, as a community service.

Today's community hospital . . has ceased to be an isolated institution, Dr. Rogers declared. "Rather," he said, "it has become a friendly and active part of community life. It is the place where most members of the community enter this world. And it will be the place where many of us will spend our last hours in the knowledge that through its services we will be well cared for.

"It may cost us money, but it saves us money, too, through its contributions to keeping us well and restoring us to health. . .

"Through these functions the hospital serves as an important part of our personal and community structure." ■

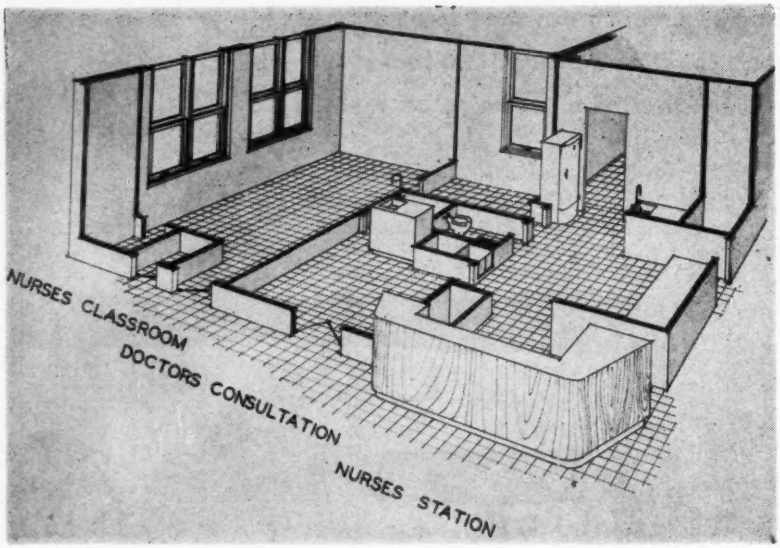


FIG. 1—Emphasis at the Variety Club Heart hospital is on research.

Traffic Control . . .

FIG. 2—Nurses Station at Variety Club Heart, University of Minnesota.

With a Minimum Staff

When designing the smaller hospital, don't overlook personnel often perform several functions

■ PROPER CONTROL of traffic using a minimum staff is one of the major problems in designing a small hospital. This is the opinion of a Minneapolis, Minn., architectural-engineering firm which has specialized in the hospital field.

W. H. Tusler, principal in charge of hospital design for Magney, Tusler and Setter, points out that too often this problem is overlooked or not given proper consideration.

"In larger hospitals, with more complete staffs, this problem is not too acute," he points out. "But the smaller hospital, working on a more limited construction and payroll budget, must have its important services designed not only for double utility, but designed so that they can be manned by a small staff with a minimum of time, steps and energy.

"We constantly bear in mind that in the smaller institutions personnel will often perform more than one function."

These sketches . . of special areas in four small community hospitals and one specialized hospital . . point up the methods which this firm has used to solve the double problem of personnel operation and close interrelationship of similar activities.

Nurses Station, Classroom, Consultation . . There are two stations similar to this one — one on each patient floor . . at the newly-opened 78-bed Variety Club Heart hospital in Minneapolis. (see two illustrations, left.) This is the only hospital in the United States devoted exclusively to cardiac care and research, and as such special design problems were involved.

Because of the heavy emphasis on research, it was essential to have consultation rooms at the nurses stations where doctors confer on cases, as well as classrooms where instructions may be given nurses and cases analyzed in group discussions. The stations themselves are located at intersection of the two main corridors on each patient floor, thus giving control of traffic in all directions. Note the separation by glass between the outside public counter and the inside desk and working area for nurses in the photograph (left).

Operating and Delivery Suites . . The entire north wing of the small, one-story Gaylord Community hospital (see Fig. 3) is devoted to operating and delivery rooms, and has features that few communities of 1,200 population would ever expect to have in a local hospital.

Note in the sketch how complete the separation is between operating

and delivery; yet central supply and sterilizing rooms are handy to both. There is a separate entrance into the hall (far right) for delivery, and to the right of scrub-up is a two-bed labor room, not shown in the sketch. Operating litters enter through a separate entrance, thus keeping contaminated cases completely separate from delivery. Lockers, x-ray and laboratory facilities are easily accessible to the entire wing.

Non-sterile Supply Room . . One of the special problems on the first floor of the Stevens county Memorial Hospital, a small two-story hospital, was to find a central location for a non-sterile supply room. This was placed next to the emergency operating room, and has a special locker for splint storage. (See Fig. 4).

The entrance to the emergency operating room, at far right, is only a few feet away from the hospital's ambulance entrance. The entrance in the foreground is across the hall from x-ray and the hospital lab. The emergency operating room has two sinks . . one for scrub-up and one for plaster. The non-sterile supply room has adjustable shelves in the main storage wall, and has sufficient floor area for handling a full-size oxygen bed and orthopedic bed, items that often end up in a corridor for lack of better supply facilities.

Emergency Cases . . Efficient and fast handling of emergency cases is provided for in the suite arrangement of the emergency operating and x-ray layout of the Lutheran Hospital, Bemidji, Minn.

continued on page 99

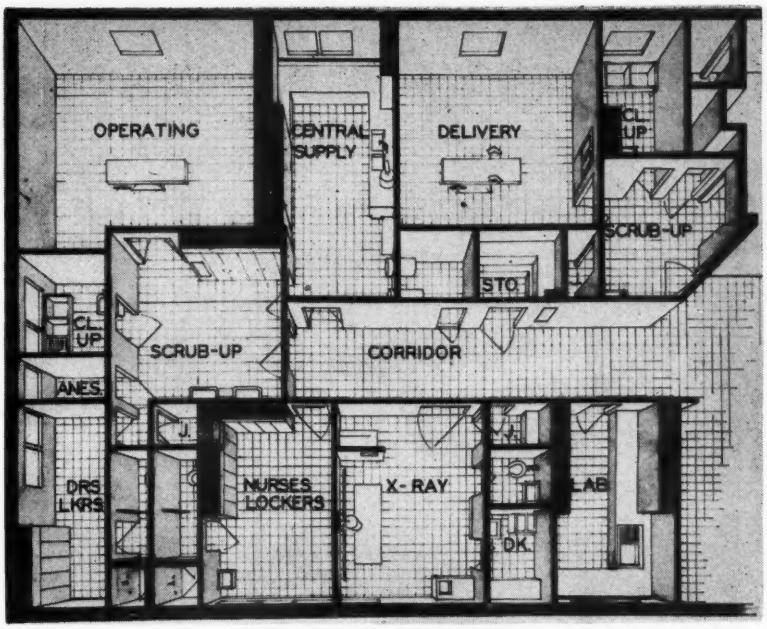


FIG. 3—Operating and Delivery Suites of the Gaylord (Minn.) Community Hospital (20-beds)

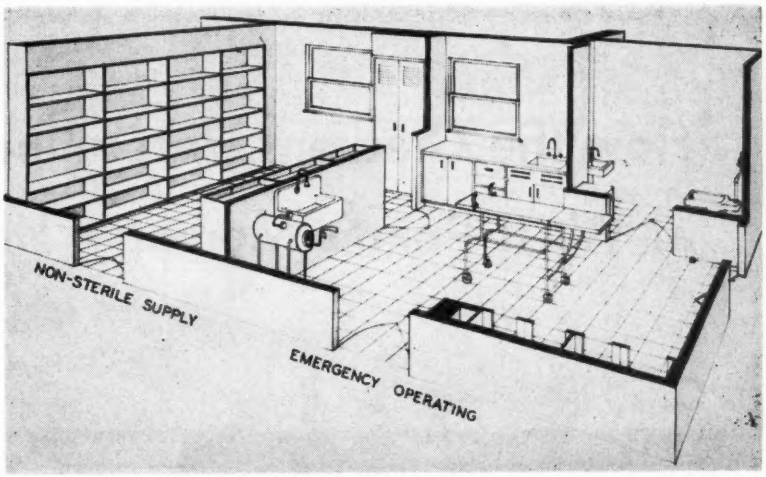


FIG. 4—Emergency Operating and Non-Sterile Supply layout at Stevens County Memorial Hospital, Morris, Minn., 50 beds.

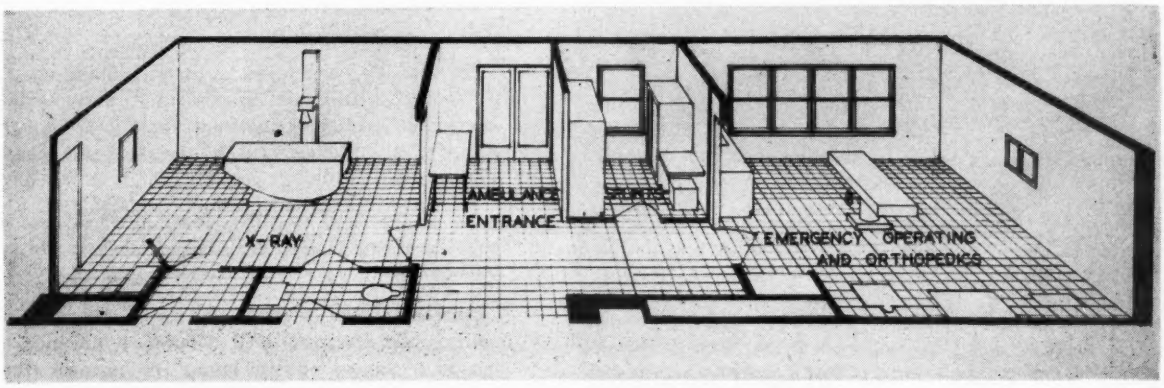
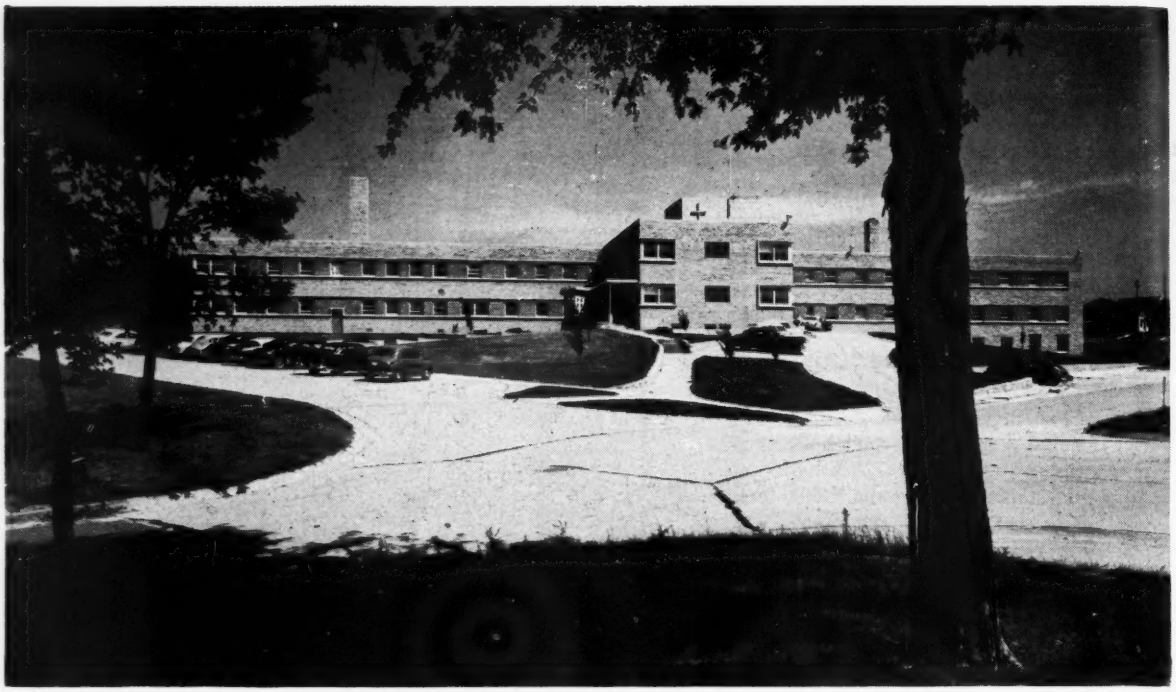


FIG. 5—Emergency Operating and X-ray layout at Lutheran Hospital, Bemidji, Minn. 93 beds.



GENERAL PERSPECTIVE of West Point Memorial Hospital. Center: main public entrance; right of center is the ambulance drive

How the Gradient Determined Construction at West Point's Memorial Hospital

Terrain affects radically the location of a new hospital and the way it's built

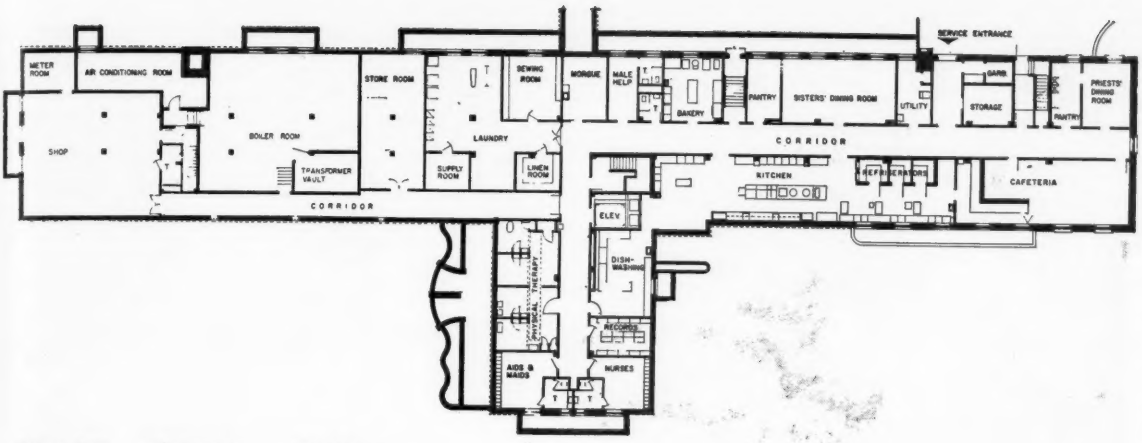
Main public entrance . . shows gradient of site, decorative solution

■ WEST POINT MEMORIAL HOSPITAL provides, for the town of West Point, located in the heart of the agricultural and cattle-feeding area of northeastern Nebraska, the hospital facilities necessary for a community located some distance from a large urban area.

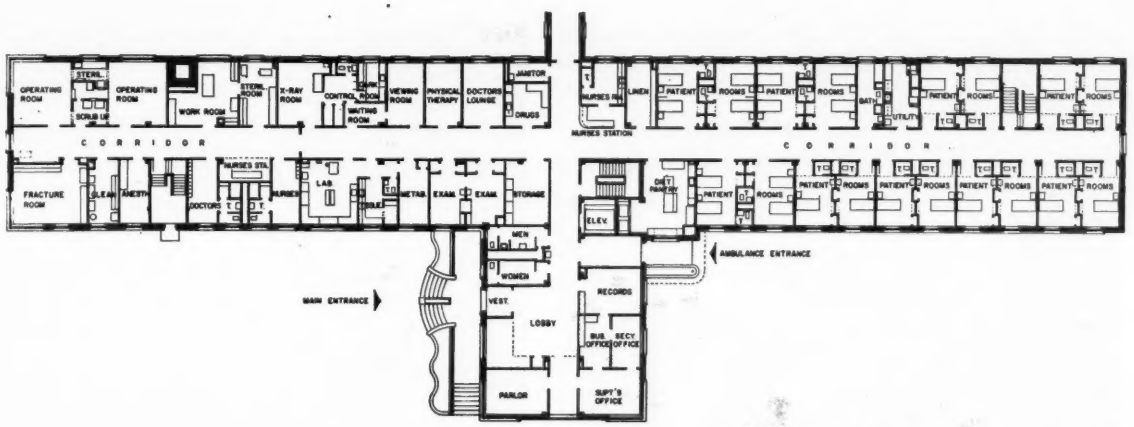
The plan was conceived to fit the sloping contour of the site. The problem presented, and resolved, was a skillful integration of entrances to the hospital with the varied levels while at the same time changing the grade as little as possible.

All of the large service areas, kitchen, laundry, mechanical equipment, etc., are located on the first floor.

Because of the sloping contour of the site, the main public entrance and ambulance entrance are located on the second floor level. The business offices are located just off the public lobby. On the second



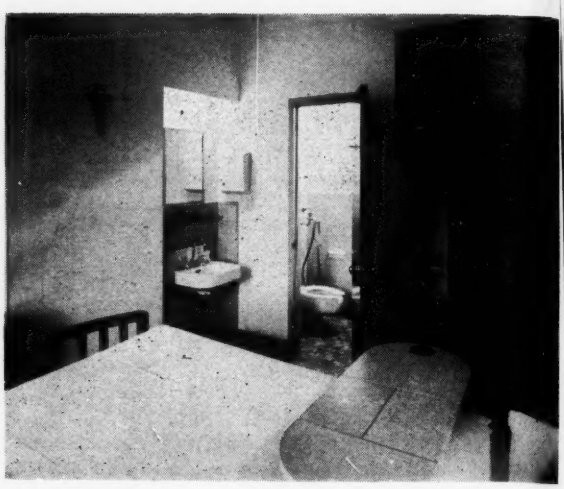
FIRST FLOOR PLAN



SECOND FLOOR PLAN

THIRD FLOOR PLAN

NURSES STATION . . with neat files, walnut counter



SINGLE PATIENT ROOM . . has adjoining lavatory and toilet

WELL-EQUIPPED O.R. . . is one of two in suite

MAIN KITCHEN . . with stainless steel equipment

floor, one wing of the large rectangular main hospital section is devoted to examination, x-ray, operating rooms and allied services. The other wing provides general hospital rooms.

Two delivery rooms, nursery and accessory services are located on the third floor. A special area has been set aside for children, ages 6 to 12.

Labor rooms and operating rooms are air-conditioned.

Construction is concrete skeleton with masonry curtain walls.

Building Issue

The exterior of West Point Memorial Hospital is finished in warm buff brick and stone trim. Planting boxes lead from the street up to the main public entrance which is flanked by square pierced supporting walls for the concrete canopy. The tower is finished in cut Bedford stone.

Ceramic tile, terrazzo, quarry tile, plaster and acoustic tile have been used to give the interior a clean, efficient but comfortable feeling.

The hospital is heated by a low pressure steam boiler with convectors and wall radiation units distributing the heat.

The elevator is located in the tower . . the core of the structure. The pantries on each floor are serviced by a dumb waiter from the kitchen which is directly below.

Oxygen is piped from a central store room to points of use.

Another factor that had to be considered was the incorporation into the design of living quarters for the Sisters of Christian Charity who operate the hospital. These living units are contained in a structure, of the same general design, located just to the rear of the hospital. The two sections are connected by a corridor. Also provided in the living unit are a chapel, library and community rooms. ■

A good reason to switch from glass to all plastic Cutter I. V. sets

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BERKELEY, CALIFORNIA

OVER-ALL aerial perspective of the buildings, old and new, of various architectural styles, which are The Johns Hopkins

Building Brings New Horizons to Johns Hopkins

Highlights of the Johns Hopkins story, showing how its construction program is adding new laurels to an illustrious history . .

■ DURING THE PAST YEAR a new, fifteen-story building has risen to dominate the East Baltimore skyline.

The new structure, part of The Johns Hopkins, stands on the site formerly occupied by a compact three-story building which only a comparatively few years ago was known as "the new Surgical Building."

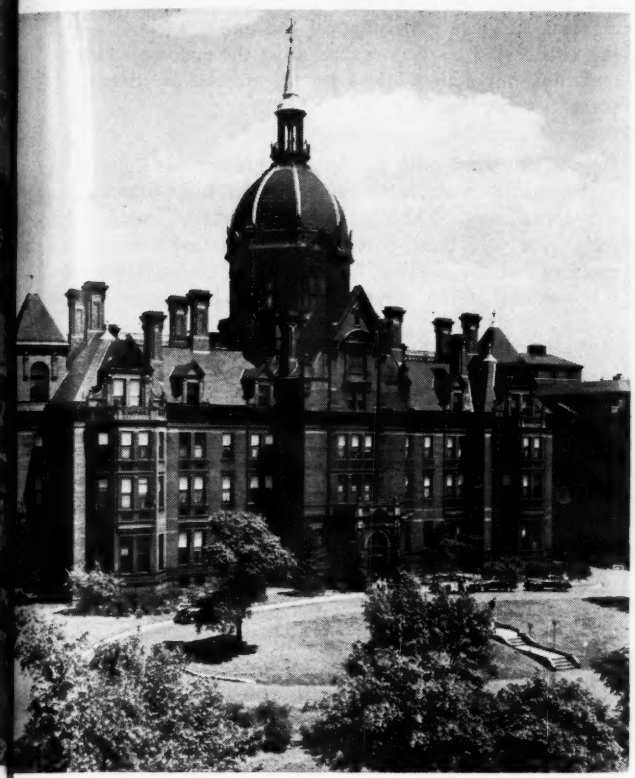
Although its completion date is scheduled for the early part of this year, the first of the hospital departments was installed last fall.

The building is the first major replacement unit in the recently-inaugurated building program of the Hopkins Medical Institution, an essential part of the long-range development program of the Hopkins University and Hospital.

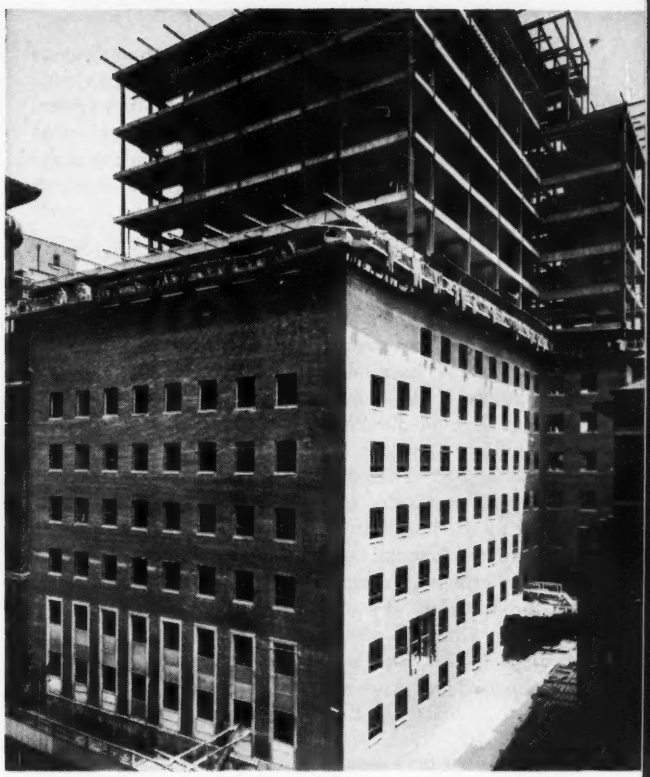
Raison d'etre . . It's a program made necessary by the phenomenal growth of medical and scientific knowledge during the past several decades, bringing with it changing patterns of patient care and prevention of disease, medical education and research. By the sheer volume of its accomplishments in the service of mankind, modern medicine has outgrown and made obsolete the facilities of plant and equipment that seemed adequate just a few short years ago.

The Johns Hopkins Medical Institutions are made up of the Hospital, the University School of Medicine and School of Hygiene and Public Health. It would seem relatively simple to describe the function of each unit: the Hospital, the care of sick and injured persons; the School of Medicine, the education of medical students and carrying on of medical research; the School of Hygiene and Public Health, the training of physicians in public health and the prevention of disease and investigation in that field.

Man-centered . . Actually, however, no such clear-cut segregation is possible, for the "whole" is much greater than the sum of its parts. The three are engaged in a joint enterprise in the field of human health; no one of the institutions could function to the limit of



OLDEST building on campus is the Administration Building



NEWER construction is 15-story addition to Baltimore skyline

Photo by Schaef

its capabilities without the close cooperation of the others. The activities of the three have been compared to three circles which overlap one another, the area common to each being man himself.

The importance of such integration was recognized by Johns Hopkins himself, nearly 16 years before the hospital was opened in 1889.

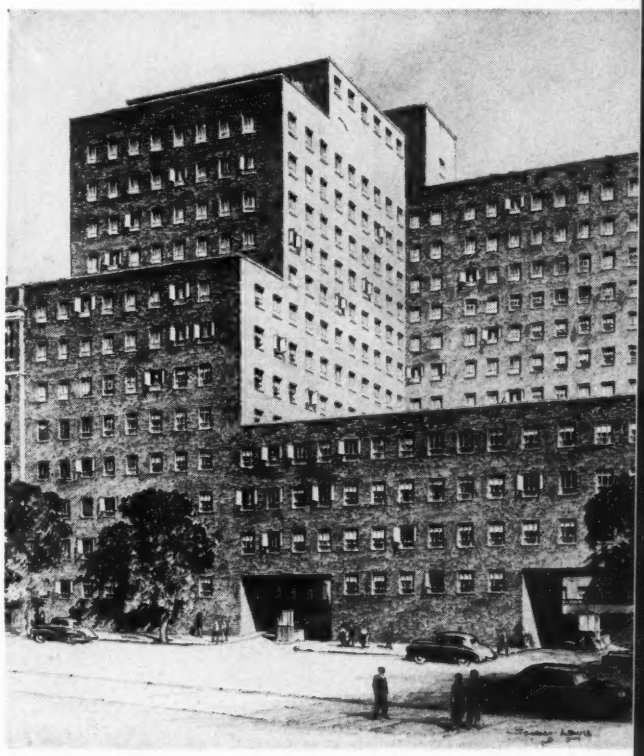
"Teaching" . . From the very start, The Johns Hopkins Hospital has been a "teaching" hospital, devoted not only to the relief of suffering but also the advancement of knowledge and the training of doctors and nurses.

In just a few months after its opening, the Training School of Nurses was started and from the beginning set a high standard of education which helped to raise the general level of nursing education throughout the country. Just three months later, post-graduate courses in medicine, surgery and gynecology were started for doctors.

With the opening of the School of Medicine, the unique relationship between the two institutions led to the establishment of new methods and patterns in education, research and patient care which revolutionized American medicine.

Under the leadership of the famous "Four Doctors" of the Hopkins . . William S. Halsted, Howard A. Kelly, William Osler and William H. Welch . . the first residency training system was developed in 1897 with the

Photo by Schaef



NEWEST structure, still in the drawing board stage

appointment of the first graduates of the School of Medicine as house officers in the hospital.

The development of bedside teaching and continuous devotion to research and the seeking of new knowledge brought about a high quality of patient care not known in the United States at that time. The quality and scope of the work brought about new procedures in the diagnosing and treatment of illness and patients, students and doctors were attracted to Baltimore from all parts of this country and many foreign lands.

Past set-up . . To outline in detail the subsequent growth and development of the Institutions from those early years to the present would require volumes.

The original hospital consisted of seventeen buildings, chiefly of one- and two-story construction, eleven of them devoted directly to patient care and the others to ancilliary services such as kitchen, laundry and nurses' home. These were arranged chiefly on the north and west sides of the same four-block area occupied by the hospital today.

Today, the hospital contains 990 beds and 75 bassinets and has grown to more than twice the size envisioned by the founder. From 1912 when the Harriet Lane Home for Children was located on the hospital ground, through 1933 when the Thayer wards in the original octagon building were remodeled, replacement and addition to the plant took place in almost continuous succession.

With the growth of the physical plant came addition and expansion in the size and number of departments and services. In 1899, there were but four services . . medical, surgical, gynecological and pathological . . and the entire staff of doctors, including the superintendent and the out-patient department, numbered twenty-three.

O.R. SCENE of historic interest is this operation performed by the famed Dr. William S. Halsted

Present-day schema . . Today there are nine greatly expanded main departments with ten fully-organized sub-departments. The staff now numbers nearly 500 full- and part-time doctors, the large majority also members of the medical faculty in the University, and a house staff of 188 interns, assistant residents and residents.

The nursing staff and the nursing school, the social service and dietary departments have shown similar growth while the number of employees in other capacities such as maids, orderlies, housekeeping department workers, laundry, maintenance and administrative personnel numbers in excess of 2,500 persons.

The Johns Hopkins Medical Institutions have been outstanding in the training of medical teachers and investigators and it would be difficult to find an accredited medical school in the nation that does not have Hopkins-trained men on its faculty and staff. More than 300 medical alumni hold the rank of professor in 50 different medical schools.

Through its contributions to medical knowledge, which have had significant influence in the improvement of patient care and public health throughout the world, the Hopkins stands now on the threshold of a new era in the field of medicine.

Needs . . To continue to be a leading force in those predicted advances and to continue to provide the highest possible level of patient care and education, the Hopkins must re-design and re-tool its physical plant, add to its facilities in the way of modern laboratories and equipment and strengthen its financial resources.

Under the growing requests by doctors at home and abroad for admission to the School of Hygiene and Public Health and its equally expanding research requirements, it is planned to add two wings, one on either side of the eight-story building which will enlarge its capacity by more than one-third.

In the School of Medicine, at least three of its five buildings are obsolete and no longer sufficient for their purpose. These must be replaced at the earliest possible time to provide laboratories and other educational facilities.

But it is within the hospital plant that the greatest need for development lies. In the incredibly short space of approximately 15 years, the design of plant layout and buildings has become inefficient for the provision of modern patient care.

"Medicine can no longer be carried in a small black bag," it was stated by a prominent medical figure just a few months ago. The doctor in his office cannot supply the laboratory service, the services of trained specialists and technicians, the costly equipment needed in the diagnosis and treatment of disease. He has little choice except to bring his patient into the hospital where he and the patient may find these benefits. ■

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STANDARDIZED FURNITURE and a multi-purpose bed in new patient rooms is one of many phases of an . . .

Alteration Program Designed To Lighten the Work Load

This expansion program for St. Luke's Hospital, Kansas City, Mo., provides increased bed space and service area

■ THE NEW BUILDING and alteration program for St. Luke's Hospital was planned specifically for additional bed space and increased service areas, keeping in mind equipment and arrangements that would lighten the work load of the personnel. In addition to these factors it was felt that the entire hospital should be made as warm and inviting as possible to the patients as well as their visitors.

In planning for additional beds it was felt that two, three, and four bed rooms were needed more than single bed or private rooms. While private beds were not left out of the planning completely, only eight beds out of a total of 125 aidditional beds were so designated.

In equipping the new patient rooms, furniture was selected with an eye for standardization, within the limits of the budget, both in color and in usability. The new equipment was selected to match as nearly as possible the majority of equipment already in service. Existing equipment that could be rehabilitated, was painted and refinished to match, ultimately resulting in a single color scheme throughout the hospital with only upholstery fabrics changing as the occasion demands. This permits us to move patients in beds, when necessary, to any room in the hospital and have all of the furniture match instead of having a conglomeration of various types of furniture in some rooms. In addition, a multi-purpose bed was chosen for all the rooms, incorporating features that would permit us to attach I.V. standards, Balkan frames, and other orthopedic attachments with a minimum of additional equipment and trouble.

Formica, one of the modern miracles of science, was specified for all of the bedside units such as cabinets, over-bed tables and dressers at a minimal additional charge. Since this material is impervious to most solutions, it was felt that the additional cost would be returned many fold in reducing the cost of refinishing and in decreasing the time and effort of the housekeeping staff.

Five-inch castors, in opposition to the normal equipment of three inch, were specified for all of the beds to facilitate moving them to other areas in the hospital. Although we try not to move beds any more than absolutely necessary, there are some cases, particularly orthopedic in nature, that require that the patient be transferred to surgery and back to his room in a bed rather than by a wheeled litter. With the establishment of a new post-anesthesia room, it will no doubt be necessary to use beds as vehicles for transferring patients more frequently than has been done prior to the establishment of this improvement.

• **Utility rooms . .** In designing service areas throughout the new wing a utility room was planned in between the three-bed and four-bed rooms. These utility rooms, designed to save steps for the personnel, include a bed pan washer, lavatory, stool, and lockers. Small lockers were installed flush with the wall to accommodate bed pans, basins, and other necessary equipment for each patient. Regular size lockers were installed in the patients' rooms to accommodate patients' clothes and personal effects.

In addition to these utility rooms connecting the three and four bed rooms, a large general utility room was planned for the space adjacent to each nursing station. These utility rooms include metal cabinets for storage space, a sink unit with cabinets above and below, locked medicine cabinets, an ice cube machine, a water sterilizing unit, and two large instrument cabinets. A two cubic foot electric refrigerator was also included to take care of refrigerated medicines and liquids so necessary to every nursing unit.

• **Flower room . .** Each nursing unit also has a flower room with a deep sink, counter and shelf space which allows the attendants to arrange bouquets and flowers in a central location and not clutter up the patients rooms with the neces-

sary preparation. There is enough cabinet space in this area to permit additional storage space for items that are not normally used everyday.

• **Wall protection . .** Another feature that was planned for in the early blueprint stages was a four-inch stainless steel cart rail at cart height above the floor in all corridors. This has worked out quite well in cutting down damage to corridor walls. However, the fact that so many carts are not the same height and have projecting parts has caused damage at a lower level. A better and less expensive idea would be to have a cement moulding or cove base at the floor level that would permit the carts to come only within a certain distance from the wall, thus preventing as much damage. Another aid would be the use of cement plaster which would not mar as easily as finish plaster.

• **Color scheme . .** With the thought in mind that a colorful as well as a utilitarian floor should be used, two basic colors, green and beige, were selected for the basic background. In the service areas where a lot of travel occurs, the beige floor was used. In the corridors, a beige background with green themetile and green border was used, an exact design being used at definite intervals throughout. The patient rooms featured the same type of floor with the basic field being altered between green and beige to give variety. Elevator areas were demarcated by the use of solid green tile, readily noticeable from any location in the corridor. The tile pattern was changed for the sun rooms on each floor, although the same color tile was used.

• **Facilities for children . .** In the pediatric unit use was made of alphabet letters, numbers, and animal figures to interest the children and make the rooms look like playrooms. Child size stools, wash stands, bath tubs, and drinking fountains were installed at a height easily accessible to children up to 14 years of age. The bathtubs were installed on raised platforms so that the attendants can bathe the children without stooping.

• **Oxygen banks . .** In the new addition a central oxygen manifold and a central duplex suction system were installed. The oxygen manifold consists of two five-tank banks with automatic controls that shift from the nearly empty bank to the full bank and indicate by a signal light in the engine room that there is need to change the tanks on the exhausted bank. In addition to the 10 tanks installed in the bank, there are 10 additional tanks kept on hand in the oxygen room so that an adequate supply is kept on hand at all times. This also affords a reserve of several tanks in case of emergency in the hospital area not included on the manifold. Each room, including the operating suites and delivery suites, has one outlet. In case of more than one patient in a room needing oxygen, a duplex outlet has been provided so that two flowmeters can be attached. In case more than two patients in a room are in need of oxygen, tanks with flowmeters have to be provided.

In conjunction with the new oxygen manifold it was necessary to establish some method of metering so that oxygen charges could be made uniformly and yet not overcharge the patient. Therefore the use of a new metering device which automatically records the number of liters of oxygen used has been adopted both for the manifold system and for use on tank oxygen. It has afforded a method of charging patients throughout the hospital in a fair and equitable manner. A minimum charge for oxygen is made and all additional oxygen used is charged for at a rate based on the cost of oxygen to the hospital.

Rooms were decorated in pastel colors, the outside wall being painted with the lighter color and the inside walls with the darker color. A flat white or flat ivory was used for all ceilings not covered with acoustical tile. Six colors were used for the walls; peachtone, sunshine yellow, turquoise, ivory, and two shades of green. All of these colors were light enough to make the rooms look cheerful and light. Corridors were also painted with the same colors and in addition several not used in the rooms were used, a darker wainscoting being painted up to the height of the cart rail. Sunporches and the reception room departed from the general trend of painting and floor design in that the inside wall of each of these rooms was papered with Varlar. The floors were altered by changing the pattern, and laying the tile in diagonal lines. Comfortable lounge furniture with occasional tables and lamps completed the homeliness of the waiting rooms. We have found that they are used as much by the patients themselves as they are by the visitors and families of the patients.

• **Diet kitchen . .** Each nursing unit caring for patients has a large airy diet kitchen that is equipped to serve food on a central service basis. The prepared food is brought to the floor in bulk in a heated food cart, and the trays which have been previously set up on the floors are loaded and served to the patient by the dietary aides on the floor. Dish warmers were included for preheating the dishes. A refrigerator, sink, tray racks, cabinets and counters, toaster, and gas range complete the equipment in these units. The toaster and gas stove were installed to permit the dietary aides to prepare and serve breakfast and special diets that have to be prepared in the nursing unit. The majority of special diets however, are normally prepared in the main diet kitchen under the supervision of a dietitian.

• **Operating rooms . .** Five major and three minor operating rooms comprise the operating suite. In one major operating room a conduit was installed to a control panel and then to classrooms and offices for the installation of television at a later date as the teaching program progresses. A small substerile work room was planned to connect each pair of major operation rooms, including stainless steel sink and drainboard, sterile water supplies, heated storage cabinets for fluids and blankets, and a high pressure steam sterilizer for rapid sterilization of instruments between cases.

continued on page 56

Building Issue

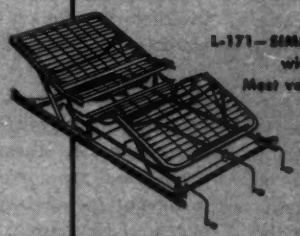
SIMMONS · Furniture · SIMMONS COMPANY

More hospital tested products

SIMMONS simple ABC method

A

FIRST SELECT THE SPRING YOU WANT.
In addition to those shown here, many others are available*—including a new motor-driven model.



L-171—SIMMONS 3-CRANK SPRING, with center wing section. Most versatile spring made.*

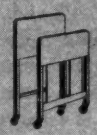
L-190—SIMMONS SELF-ADJUSTING SPRING. Patient or nurse can operate. Saves time.*

L-146—SIMMONS NEW 2-CRANK SPRING. Redesigned to provide more positions, including Trendelenburg and Hyperextension.*

+ B

NEXT, SELECT THE STYLE OF BED ENDS YOU WANT.
Six of Simmons ten popular models are shown here. They are available in colors or wood grain finishes.

H-800—Standard 7-Filler End.*



H-846—Semi-Panel End.*

H-803—4-Filler Tubular End.*

H-880—7-Filler Vari-Hite.*

H-885—Solid Panel Vari-Hite.*

H-835—5-Filler Graceline.*

For complete details see your hospital supply dealer, or Simmons new Hospital Catalog No. 26.

SIMMONS Bed Ends offer You a Choice of Service Features

Bed H-800-1. STANDARD BED ENDS—indicated by the suffix number (-1) added to the bed number. Have no special provisions for attachments. However, they may be equipped with portable safety sides. Available in complete range of Simfast finishes.

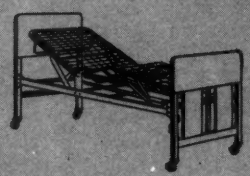
Bed H-800-2. BED ENDS WITH SAFETY SIDES—indicated by the suffix (-2) added to the bed number. Equipped with special brackets for H-86 and H-4 Safety Sides. They safety sides operate in vertical plane. End guard rails may be attached to safety sides

from SIMMONS complete line

makes it easier to pick the springs and Bed Ends you want!

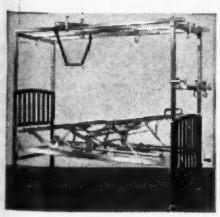
HERE ARE A FEW OF THE MANY COMBINATIONS you can make with Simmons interchangeable springs and bed ends. Simmons Springs may be purchased only for Simmons Bed Ends.

H-880-L-171
—7-filler Vari-Hite Bed Ends (H-880), with 3-crank Deckert spring (L-171).*



H-846-L-146
—Modern Semi-Panel Bed Ends (H-846), with improved 2-crank spring (L-146).*

H-800-L-190
—Standard 7-filler Bed Ends (H-800), with Self-Adjusting spring (L-190).*



Bed H-800-3. ALL-PURPOSE BED ENDS—indicated by the suffix (-3) added to the bed number. Have stainless steel baffle bars; built-in sockets for attaching demountable Balkan Frame H-16, Irrigation Rod H-69, and H-16E Shaped Fracture Bar. Have brackets for safety sides.

You'd Expect this of SIMMONS

Simmons, with the aid of down-to-earth suggestions from hospital administrators, doctors and nurses, has been busy working out a flexible system of interchangeable units—springs and bed ends—to help hospitals provide economically the many types of bed service they are expected to supply.

Now you can pick combinations of bed springs and ends which will enable you to provide all bed services with the minimum number of units—for surgery, obstetrics, fracture, convalescent, or special departments such as mental, heart and contagious. Your selection of ends is made easier because most Simmons bed ends are available plain, with brackets for safety sides, or with all-purpose features.

That's not all. You can choose from a wide range of easy-to-clean pastel colors or attractive wood grain finishes when you buy Simmons bed ends. Thus, your rooms and wards can be planned for color harmony as well as maximum service.

Simmons ABC System of Interchangeable Units as outlined here presents the basic idea. But to really understand the wide range of choice and the economy this system provides, see your hospital supply dealer, or visit a Simmons sales room.

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HOSPITAL DIVISION

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With this equipment it is now possible for the surgeon to finish a case in one operating room and almost immediately start the next case in the adjacent room. This practice has been followed where a few surgeons have a large number of surgical cases scheduled for the same day.

The sidewalls of these operating rooms are glazed green tile to a height of six feet, green upper walls to blend with the color of the tile, and a lighter green on the ceiling. Central operating lights provide light during the operation, and four recessed lights provide light for clean up and preparation. The corridors were widened to ten feet instead of the normal eight feet to accommodate the operating tables, beds and litters that are used. To break the monotony of the completely green operating room, brown tint was used as a painted wainscot in the corridors and a peachtone was used above the stainless steel cart rail. The work area for surgery consists of two large rooms centrally located within the department. These two rooms are separated by a battery of double door sterilizers, the unsterile material, being prepared and sent through the autoclave from one room, taken out and stored for future use in the other room. An instrument room consisting of cabinets mounted in all four walls provide storage space for all of the instruments of the staff men.

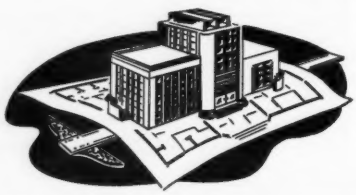
The supervisor's office is located near the entrance to the suites so that she can, to a great extent, control the traffic that enters the operating rooms. Included in the office is a small partitioned office to accommodate dictating equipment so that the surgeons and their assistants may dictate the details of the case as soon as it has been completed. Glass boards mounted in the walls in two locations indicate the cases scheduled for the day, the time of the operation, name of patient, name of the surgeon, and the type of case.

The nurses lounge and the doctors dressing room were decorated in distinctly contrasting colors to relieve the monotony of the complete greenness of the suites. A coffee bar, table, lounge chairs, and a divan have been provided for their relaxation.

In the first floor service area, two emergency rooms, an outpatient business office, reception room, clinic space, physical therapy treatment rooms, hydrotherapy pool, a plaster room for the application of casts, and a dozen examining rooms have been provided for the use of the medical staff. Rest rooms and a modern pharmacy, complete with storage space, have been provided to complete the services so vitally necessary to the operation of the hospital.

• **Ambulance entrance . .** The ambulance entrance affords inside access out of the weather for patients entering the hospital and seeking emergency treatment. A signal system activated from the entrance, advises the nurse on duty that a patient is on his way in. A cart storage space, completely tiled, immediately adjacent to the entrance of the emergency room provides adequate storage space for wheel chairs and litters. The ambulance entrance is situated between the existing building and the new additions, and therefore is as centrally located as the physical arrangement of the buildings permit.

The business office with the cashiers windows will be so arranged that it is centrally located to the entire hospital, and complete unto itself, so that all the business office functions are incorporated in a single area. The telephone switchboard is being moved to a new location and isolated from all other departments so that the hustle and bustle of hospital life will permeate their domain only through the telephone. A new signalling system, in addition to the page system is being installed so that the check-in board for the staff men activities the telephone directory board and the operators can tell at all times when a doctor is in the hospital. A switch box connected with these directories indicates by a flashing light that a message is being held for the staff man at the information desk.



Building Issue

A new central supply service is being established with sub-sterile and sterile sections, which will improve the service that it gives to the patients. With a dutch door or a window established at one end for issuance of supplies, it should be increasingly easier for a complete inventory of central supply items to be maintained.

The entire basement area of the new wing will be devoted to a central warehouse. In this area there will be kept broken lots of all the items used in the hospital, adequately stored in bins and marked for easy access. A delivery chute, leading from a dock at the main floor level, provides easy delivery of bulky items. Large case lot shipments will be stored in an area across the parking area from the main hospital and be easily accessible for replenishing the daily stocks.

In the obstetrical suite use was made of folding plastic doors to conserve space. When in use, the folding doors are closed and were so installed to leave an open area both above and below the door, permitting ease of conversation without entering or leaving the room. The work area again consists of two large rooms centrally located within the department with the arrangement of the sterilizers similar to that of the operating suites.

In redesigning the food service unit a new cafeteria style service was used, using lowerators throughout for ease in storage of dishes and speed in serving. Stainless steel, of course, was used for utilitarian purposes and also for a nice appearing installation.

A snack bar was designed for one small dining room incorporating steam pans, ice chest, toaster, and coffee maker so that late evening meals can be served for employees without opening up the main cafeteria. This is to be installed in an area accommodating 35 people so that it should take care of all the evening meals that are anticipated.

"FOR A *SPEEDY* RECOVERY . . ."

MULTIVITALIN
Intravenous
10 cc. Ampuls
Boxes of 25 and 100

Note to the Physician

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Clinical studies indicate definite stimulation of wound healing, decrease of post-op. vomiting and nausea, and subjective increase in feeling of well being. No toxicity noted.

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The sealed cellophane packet is your guarantee of freshness. Protected this way from moisture and humidity, the crackers can't go stale. Each packet contains just the right amount for one serving of flavorful, puffy oyster crackers—slightly salted on top and perfect for oysters, soups and cocktails.

RITZ CRACKERS

Here, in the convenient cellophane packet, is America's favorite cracker. Loss through bottom of the caddy breakage is a thing of the past . . . and the packets assure equal portions, two crackers each, per serving. Salty and crisp, Ritz packets are the perfect mate for entrees, soups, salads and cheeses.

SEND FOR THIS FREE BOOKLET

Packed with ideas on how to increase sales and cut food cost with DANDY OYSTER Crackers • RITZ Crackers • FOUNTAIN TREATS • PREMIUM Saltine Crackers and other NABISCO products. ®

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Kindly send your booklet "Around the Clock with Nabisco."

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individual food packets!

saves time!...top quality!...

FOUNTAIN TREATS

Add that extra touch to your hot and cold drinks, sodas and ice-cream by serving Fountain Treats in the cellophane packet. Serving time is cut and waste, through breakage and staleness, is eliminated. Handsomely displayed in each packet, the delicious chocolate and vanilla sweet cookies are fountain favorites.

PREMIUM SALTINE CRACKERS

There's nothing quite like these flaky, salty Premium Saltine Crackers in the cellophane packets. The packet is your assurance that they'll taste oven fresh always—and you save money because there's no breakage, wastage either. Serve with soups, chowders, salads—and as a thrifty substitute for bread.

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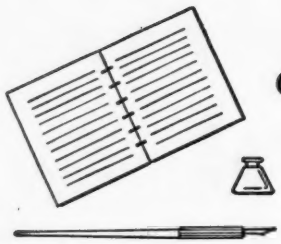


administrator's diary

by Herbert Krauss

February • 1953

3 Annual fire inspection for state license renewal. New Formica top dining room tables arrive. Long, narrow, decrepit thick-legged old ones go to employees for one to three dollars each. Placed order for mattresses for new wing with local house. Sample mattress for new longer beds is measured.

5 Royal Sater, 99-year old patient in 135 (which we just happened to finish decorating) signs a will leaving the hospital a 320-acre farm, and smaller farms to each of two nearby colleges. He has been a self-made successful farmer in nearby New London.

6 We have lost eleven rooms during the process of connecting the new wing to the old building. Financial statement has been blushing for months. So there have been conferences to see if we can get part of the new building finished to use before the rest of it is completed. We settle on the third floor, and the contractors are shooting at 60 days. Mr. Sater leaves hospital.

7 Mr. Sater dies.

10 After our weekly Tuesday morning staff meetings I have been taking one or two department heads through the new wing with me on a tour. This morning Carol Madsen, assistant director of nursing, asked whether the door to the isolation nursery would be glass; the fathers would want to see those babies, too. Made a note to check it.

11 The discussion over sterile water tanks *vs* "flasking" continues. My phone calls to administrators of hospitals within a 150-mile radius failed to find any with new construction who switched to "flasking" when they got a new surgery.

12 Conference with construction foreman and chief plumber about losing more rooms. In order

to get their stacks up to finish third floor, they have to come through a room on first and second. So I tell the nursing department and front desk to squeeze again.

13 Conference with plumbers, then radiologists. They have to come up through the floor of the x-ray office on north fourth in order to set up the pipes for finishing a toilet room underneath on third. And third is what we want finished, so they get the "go" sign. Later they want to come through the floor of the east x-ray room; our measuring makes it look like they will come out right under the generator on the floor.

16 This hectic day may be my classic for 1953. In anticipation of tomorrow's inspection of the nursing school by a member of the accreditation office in New York, there is a certain restlessness in the top levels of the faculty and nursing department. The "visitor" is already in town and today touring the other school in Burlington.

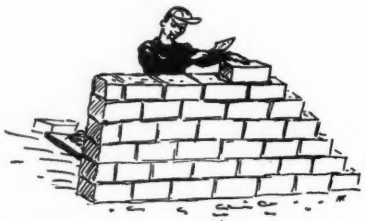
The business office has missed getting the checks out on pay day today, due to certain personnel difficulties. Hence there are worry waves being transmitted from that station.

Ruth Wehman is busy typing the final draft of my report for the annual meeting of the hospital association this afternoon and is meanwhile turning away salesmen for me.

The decorator chosen to do the drapes and help plan the color schemes for the new wing has been urged to get on the ball because we want to move into the third floor April 15. He calls and I agree to a meeting with him at 10 a.m. because he finally got the drape samples he had been waiting for. (Later I found that he was so delighted with Paul somebody's new modern design and colors at the Chicago show that he now wants to spend more than we authorized him).

Then Everett Witte from the architect's office comes in to tell me that we must make up our mind about water sterilizers or "flasking," because the plumbers and tile layers are busy in the surgery area and have been stopped because of that question. I tell him that a salesman told me that only two new hospitals in the state have switched to "flasking;" that I have written them and received one enthusiastic reply for flasking, no answer from the other. So I telephone the consultant in Chicago; I'm told he's busy on another phone.

After a while the payroll is postponed until tomorrow. Some sale-



men are seen. A plumber is advised to continue pipe laying. Consultant doesn't call. I call the decorator and cancel meeting; set it for afternoon. "Ev" suggests we call the consultant again, to indicate our call is urgent. We get through to his number; are told to wait . . he will call us.

It's lunch time and I'm due at a meeting. Consultant calls us. Apologizes for not answering letter on sterile water question. States that letter was dictated January 22 but

continued on page 83

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by the thousands in hospitals all over the nation have demonstrated their ability to give you safe, convenient service.

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Who's Who in the Hospitals

Swim star . . aids proposed Santa Monica Hospital wing

■ ESTHER WILLIAMS, swim and film star, is shown above with her husband Ben Gage (left) and Birger Tinglof, vice-president of the Lutheran Hospital Society. The couple are adding their contribution to the long list of prizes awarded winners in a golf tournament staged as a benefit for the Santa Monica Hospital building fund. Mr. Tinglof is displaying a model of the hospital building with the proposed new wing showing at the right.

Administrators & assistants

Adair, Frank B. . . Appointed administrator of Moton Memorial Hospital, Tulsa, Okla., succeeding **J. T. A. West,** who resigned after 6 years in the post. Mr. Adair, formerly on the staff of Michael Reese Hospital, Chicago, is a graduate of Harvard and a former teacher of business administration at Langston U.

Bach, Harry C. . . assumed duties as administrator, Mary Washington Hospital, Fredericksburg, Va., succeeding **Thad F. Connally,** resigned. He came from Middletown, Ohio, where he served as assistant administrator of Middletown Hospital since 1949.

Barrett, Max . . see **Beacham** notice.

Beacham, William . . Appointed administrator, Piedmont Memorial Hospital, Greensboro, N.C., succeeding **Max W. Barrett,** who resigned recently to undertake further study at the U. of Georgia. Previosuly Mr. Beacham was a member of the staff of the School of Public Health at the U. of North Carolina at Chapel Hill.

Bennett, Morton . . Appointed assistant executive director, Jewish Hospital Assn., Cincinnati, Ohio, succeeding **Marvin J. Lawrence** who resigned to accept a position with Mt. Sinai Hospital, Detroit, Mich. Previously Mr. Bennett served as the administrator of Marlborough Hospital, Marlborough, Mass., since 1946. He also is an RN, having received his degree at the Mills School for Male Nurses, an affiliate of the School of Nurses of Bellevue Hospital, NYC. He is a member of the A.H.A., the New England Hospital Assembly, the Massachusetts Hospital Assn. and Rotary International.

Burrow, Noah W. . . see **Haythorne** notice.

Caffrey Gertrude . . Promoted from acting superintendent to superintendent, Carbondale General Hospital, Carbondale, Pa., succeeding **Herbert Keyser,** who resigned last year because of ill health after 20 years in the post.

Connally, Thad F. . . see **Bach** notice.

Cooney, James P., Brig. Gen. (MC), USA . . Appointed special assistant to the Commanding General, Walter Reed Army Medical Center, Washington, D.C., after serving as Surgeon to the Japan Logistical Command. He holds the Legion of Merit with Oak Leaf Cluster for his contribution to the atomic energy program, and is a Fellow of the American College of Chest Physicians as well as a member of the Radiological Society of N.A. and the American College of Radiology.

Cox, M. P. . . Named administrator, Community Hospital, Paragould, Okla., succeeding **Eugene Lopez.** Previously Mr. Cox was administrator of Stillwater Municipal Hospital, Stillwater, Okla. Mr. Lopez resigned after 3 years in the post to become director of professional relations for Blue Cross-Blue Shield at Little Rock.

Crafts, Grace . . see **Reynolds** notice.

Cushing, Adelaide B. . . Retired as administrator of the Eye and Ear Hospital, Pittsburgh, after 28 years in the post. Her successor is **Martha C. Zavonia,** who has been assistant administrator for 3 years. Miss Zavonia's place is being filled by **Ruth Eichar,** formerly director of nursing service.

Eichar, Ruth . . see **Cushing** notice.

Gallagher, John F. . . Resigned as administrator, Meyersdale Community Hospi-

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HOW TO CUT DOWN on annual operating expense—reduce maintenance costs... that's the BIG problem facing hospital management boards everywhere.

First step in any maintenance-saving program is to insist on "Quality-Approved" aluminum windows for all new buildings and additions. In this way you automatically eliminate some of your annual maintenance expense right from the start.

Aluminum windows continue to save you important money year after year. They cannot rust or rot—they *never* need painting, costly repairs or replacement. They always operate easily and will remain beautiful for the life of the building.

"Quality-Approved" aluminum windows are available through many manufacturers in sizes and styles (double-hung, casement, projected and awning) to fit any design treatment. Only those that carry the "Quality-Approved" Seal have been tested by the Pittsburgh Testing Laboratory and approved for quality of materials, construction, strength of sections and minimum air infiltration.

For a copy of our latest Window Specifications Book and names of approved manufacturers, see Sweet's Architectural File (17a/ALU) or write to Dept. HM-3.

Pictured above: Shriners Hospital, Salt Lake City, Utah
Architects: Scott and Beecher *Contractor:* Olson Construction Company

Aluminum Window Manufacturers Association

74 Trinity Place, New York 6, N. Y.

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Officials of Baptist Memorial Hospital . . in Memphis, Tenn., at awarding of construction contract

■ FRANK S. GRONER (right), administrator of Baptist Memorial in Memphis, and Dr. Paul A. Wieland of Trenton, Tenn., chairman of the hospital's board of trustees executive committee, observe Hays E. Owen, president of the hospital's board of trustees, as he signs a letter of award of contract to the Harmon Construction Company of Oklahoma City and Memphis.

The contract, which is for the construction of the hospital's new 13-story addition, is in the amount of $5,834,487.

Construction of the new building, which will increase the bed capacity of Baptist Memorial Hospital from 500 to 750, was scheduled to get under way on or before March 15. ■

tal, Meyersdale, Pa., after a year in the position.

Harmon, Alexander . . Appointed superintendent, City Hospital, Cleveland, Ohio, after having served since last October as acting superintendent. He received his HA training at the U. of Chicago, serving his administrative residency at Stanford U. Hospitals under **Dr. Anthony J. J. Rourke.** From 1949 until he accepted the "acting" position he was assistant superintendent at City Hospital.

Hawthorne, Robert S. . . resigned as administrator, Dallas Children's Medical Center, Dallas, Texas, a post held since 1948, to accept a position with the Blue Cross Hospital Service.

Haythorne, Frank C. . . Appointed administrator, Randolph Hospital, Asheboro, N.C., succeeding **Noah W. Burrow,** resigned. Previously Mr. Haythorne was superintendent of a hospital at Greenville, S.C. for 3 years.

Jarvis, Richard, MD . . Named acting superintendent, Central State Hospital, Lakeland, Ky. The assistant state commissioner of mental health succeeds **Dr. A. M. Lyon,** who is undergoing treatment at Kentucky Baptist Hospital. Dr. Lyon, 63, will retire July 1.

Keyser, Herbert . . see **Caffrey** notice.

Lahasky, Bernard, MD . . announced the opening of a 10-bed hospital owned by him in Erath, La., which now has hospital service for the first time. The building is fully equipped for surgery and x-ray, and has a nursery, laboratory, resuscitator and an emergency room.

Lawrence, Marvin . . see **Bennett** notice.

Lopez, Eugene . . see **Cox** notice.

Lyon, A. M., MD . . see **Jarvis** notice.

McDermott, Bernard . . To retire March 31 as director of Long Island College Hospital, Brooklyn, where he has been for 28 years (as director since 1934). He is a past president of the Greater New York Hospital Assn., the Hospital Assn. of N.Y. State, and the Hospital Council of Brooklyn.

Millar, Robert C. . . Named assistant managing director, Presbyterian Hospital, Pittsburgh, Pa.

Newsome, Reuben S. . . Named assistant manager of the new V-A Hospital, Durham, N.C.

Outten, Ralph L. . . Named administrator, South Side Hospital, Pittsburgh, Pa., succeeding the late **Gertrude L. Heatley.** Previously Mr. Outten was assistant to the administrator of Montefiore Hospital in Pittsburgh. A veteran of WW II, he is a member of the A.H.A., the Southwestern Hospital Conference of Pennsylvania and the Public Relations Council of the Pennsylvania Hospital Assn.

Prusmack, John R., MD . . Named manager of the V-A Hospital, Palo Alto, Cal., succeeding **Albert W. Waldron,** who is retiring.

Purser, R. L. . . Named assistant administrator, Washington County General Hospital, Greenville, Miss. For 2 years he was administrator of what is now the Lutheran Hospital at Vicksburg; recently he has been with the Mississippi Commission on Hospital Care.

Reynolds, David C. . . Named administrator, Madison General Hospital, Madison, Wis., after serving for the past 5 years as assistant to **Grace Crafts, RN,** who recently retired after serving the hospital for over 35 years, first as director of nursing and then as administrator. Mr. Reynolds received a BA in HA from St. Mary's U., San Antonio, Texas, and following his release from the Navy, a Master's from Washington U., St. Louis, Mo.

Richard, Hubert . . Named administrator, Washington-St. Tammany Charity Hospital, Bogalusa, La., succeeding **J. Milton Roberts.** Previously Mr. Richard was assistant director of the State Department of Institutions.

Roberts, J. Milton . . resigned as administrator, Washington-St. Tammany Charity Hospital, Bogalusa, La., to accept the position of administrator of the Bogalusa Community Medical Center.

Sargent, Charles F. . . see **Bridge** notice.

Shealy, Max H. . . Resigned as superintendent, Cherokee County Hospital, Gaffney, S.C., a post held since 1947, prior to which he had been with Spartanburg General Hospital since 1939 (except for 3 years with the Army Air Forces).

Sister Bernadine . . Appointed administrator and sister superior, St. Vincent's Hospital, Sherman, Texas, where she has been business manager for the past

6 years. She succeeds **Sister Damian,** who is now administrator of St. Vincent's Infant Home, New Orleans, after 5 years in Sherman.

Tamplain, Harry J. . . Appointed assistant director of Foundation Hospital of Alton Ochsner Medical Foundation, New Orleans, La. Mr. Tamplain, a graduate of Tulane with a BBA degree, has been chief accountant at Foundation Hospital since 1948, and administrative assistant since Oct. 1, 1952.

Thiele, Walter H., MD . . Appointed manager, Atlanta V-A Hospital, Atlanta, Ga., after having served as chief of professional services at the V-A Hospital in Fayetteville, N.C.

Toomey, Robert E. . . Appointed an assistant director, Greenville General Hospital, Greenville, S.C. A graduate of the Columbia U. Course in HA, he was formerly director of the North Country Hospitals in Gourverneur, N.Y.

West, J. T. A. . . see **Adair** notice.

Wilson, David B., MD . . Appointed director of the new University Hospital, Jackson, Miss., now under construction. Dr. Wilson has been associated with the Mississippi Commission on Hospital Care since 1951.

Waldron, Albert W. . . see **Prusmack** notice.

Nursing posts

Bunge, Helen L., D. Ed., . . Appointed executive officer of the new Institute for Research in Nursing at Teachers College, Columbia U., NYC., after serving as dean of the Frances Payne Bolton School of Nursing as Western Reserve U., Cleveland.

Kaladic, Dorothy, Mrs. . . Appointed director of nurses, Mount Sinai Hospital, Minneapolis. A graduate of Milwaukee County Hospital and Marquette U., Mrs. Kaladic's past assignments as director of nurses have been at Memorial Hospital in Colorado Springs, Hilo Memorial Hospital in Hawaii and most recently at Orange County Hospital in California.

Lambright, Marion A., RN . . Appointed director of the Nursing Department, Aultman Hospital, Canton, Ohio, in charge of both nursing service and nursing education. She has served as Aultman's assistant director of nursing service and assistant director of nursing education. Previously she was for 5 years the educational director at Mercy Hospital in Cincinnati.

New England Hospital Assembly members . . examine entries in the "How We Do It" contest which is a feature of the meetings*

N. E. Hospital Assembly to hear experts

■ AMONG NATIONALLY PROMINENT FIGURES in the hospital and medical fields who will participate in the three-day program of the New England Hospital Assembly at the Statler Hotel, Boston, March 23, 24 and 25, are W. Palmer Dearing, M. D., Deputy Surgeon General, U. S. Public Health Service, Washington, D. C.; Edwin L. Crosby, M. D., president of the American Hospital Association and director, Joint Commission on Accreditation of Hospitals, Chicago, Ill.; Rear Admiral (Retired) Dallas G. Sutton, Washington, D. C.; Charles F. Wilinsky, M. D., past president of the Assembly, past president of the American Hospital Association and the American Public Health Association, executive director of Beth Israel Hospital, Boston, and Rt. Rev. Monsignor A. C. Dalton, director, Catholic Hospitals, Boston.

One hundred and forty-two speakers, experts in every aspect of hospital administration, will take part in 28 meetings during the three days. Exhibits of hospital supplies and equipment, valued at more than a million dollars, will be displayed in 100 booths by manufacturers and suppliers.

Dean A. Clark, M. D., Assembly president and general director of Massachusetts General Hospital, Boston, will preside. ■

Moser, Margaret . . Resigned as assistant directed of nurses, City Memorial Hospital, Winston-Salem, N.C., to become director of nurses at Moore County Hospital, Pinehurst, N.C.

Porter, Elizabeth K., Mrs. . . received an honorary Doctor of Science degree conferred by the U. of Pennsylvania. Mrs. Porter is professor of Nursing at Western Reserve U. and president of the American Nurses Assn.

Savage, Louise, BS, RN . . Appointed director of nursing, Methodist Hospital, Philadelphia, Pa.

Spry, Cecile Tracy, Mrs. . . Appointed to the State Nurse Planning Council of Washington. Mrs. Spry is administrator of General Hospital, Everett, Wash.

*Left to right are: Charles Caprong, Kerbs Memorial Hospital, St. Albans, Vt.; Hiram Sibley, executive director, Connecticut Hospital Assn.; Abbie Dunks, director, Boston Dispensary and chairman of the contest; and Robert D. Southwick, administrator, Concord Hospital, Concord, N.H.

Miscellaneous

Barnes, Harold R., Rev. . . Elected president, National Association of Methodist Hospitals and Homes. ■

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To the author of 'I wanna know why'

The author of this letter is replying to an article on page 49 of the September 1952 issue of HOSPITAL MANAGEMENT.

Dear Mrs. X:

You say you "wanna know why" the benefits of a certain insurance company's hospitalization policy are, as you imply, superior to those of your Blue Cross certificate. With no personal implication intended, Mrs. X, suppose I were to ask, "Has your husband stopped beating you?" The two questions would make about the same amount of sense.

The smiling, agreeable, young man who called at your home one night to sell you a commercial policy, naturally played up certain features which, at first glance, might seem better than comparable features of your Blue Cross contract. There was no Blue Cross representative there that evening to refute him by presenting a thorough comparison of the two documents. Refutation is easy, and, wearing my most agreeable smile . . though no longer, alas, with my former youthful charm . . I offer it herewith:

As you know, the 87 Blue Cross Plans are each locally governed and their rates and benefits vary; also, most of the Plans offer a choice of contract. My remarks will refer both to your own particular contract and to what might be called "typical" contract provisions embracing the benefits common to all or most of the Plans.

Your young salesman . . compared his company's 60-day coverage per contract-year with *your* Blue Cross Plan's 21-day coverage. It happens, as you know by now, that, since you wrote your HM article, your Plan has increased its full-coverage period to *70 days per hospital admission.* Apart from that, however, a 21-day period is exceptionally low nowadays among the Plans, most of which provide full coverage for 30 days or more . . some as much as 120 days . . *and* usually an additional period of 50 per cent coverage is provided, the latter averaging something like 90 days.

As a matter of fact, coverage for a long hospital confinement . . whether by Blue Cross or by a commercial carrier . . while a valuable feature of any contract, can be provided without materially affecting the premium rate. Ninety per cent of all general hospital cases are discharged before the 21st day, and in fact the average patient is hospitalized only 8.3 days. (The average Blue Cross patient stays only 7.5 days . . a fact generally attributed to his lack of hesitancy in submitting to hospitalization, so that he is hospitalized in the earlier stages of an illness and can consequently be treated more effectively and discharged sooner.)

Furthermore . . it's the first few days of a stay that are the most costly; after that, necessary services are usually more or less routine. What does the commercial policy offer during this initial period? To quote your salesman, it pays $4 per day (or $8 on a family contract) toward room and board, compared with *your* Blue Cross Plan's $5 allowance. It provides allowances (amount not stated in your article) toward cost of home nursing care, surgical benefits, and special nursing . . items not covered by Blue Cross.

But no mention is made of allowance for drugs, oxygen (both of which frequently run into hundreds or thousands of dollars on a single case), laboratory and other tests, x-ray, anesthetics, use of surgery rooms, physical therapy, etc. . . benefits which *your* Plan, like most Blue Cross Plans, provides *on a service basis,* either regardless of cost or occasionally with a liberal dollar allowance.

These are the items that run up a hospital bill. And, in the matter of room allowance, the typical Blue Cross Plan provides semi-private room accommodations without regard to cost; in most hospitals today such accommodations average more than $8 per day.

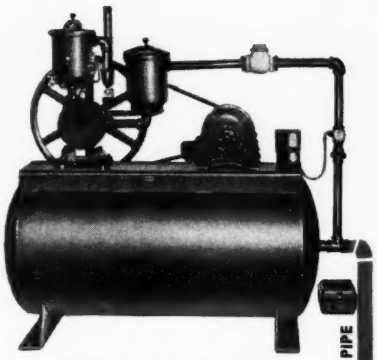
The commercial policy . . in question has a $480 limit, per year, on its room allowance, which you compare unfavorably with your Plan's $105 limit. Your "left-employ" (non-group) certificate did have this limit ($5 times 21 days) at the time you wrote; your Plan's regular group certificate provided 70 days, which would mean a $350 limit. Since November, 1952, however, your non-group certificate has likewise covered 70 days.

The $350 limit for room and board is still less than the commercial company's $480, it is true. But when all the Blue Cross ancillary benefits are taken into consideration, plus the fact that a confinement long enough to use up the room allowance limit is very exceptional, the discrepancy is more than nullified.

And, again, the *typical* Blue Cross Plan provides semi-private accommodations regardless of cost and for a period averaging long enough to make the actual limit in most cases higher than the $480 figure which the young salesman dangled so enticingly before you.

The next point . . brought out in your article is maternity allowances. The commercial salesman makes a

continued on page 78



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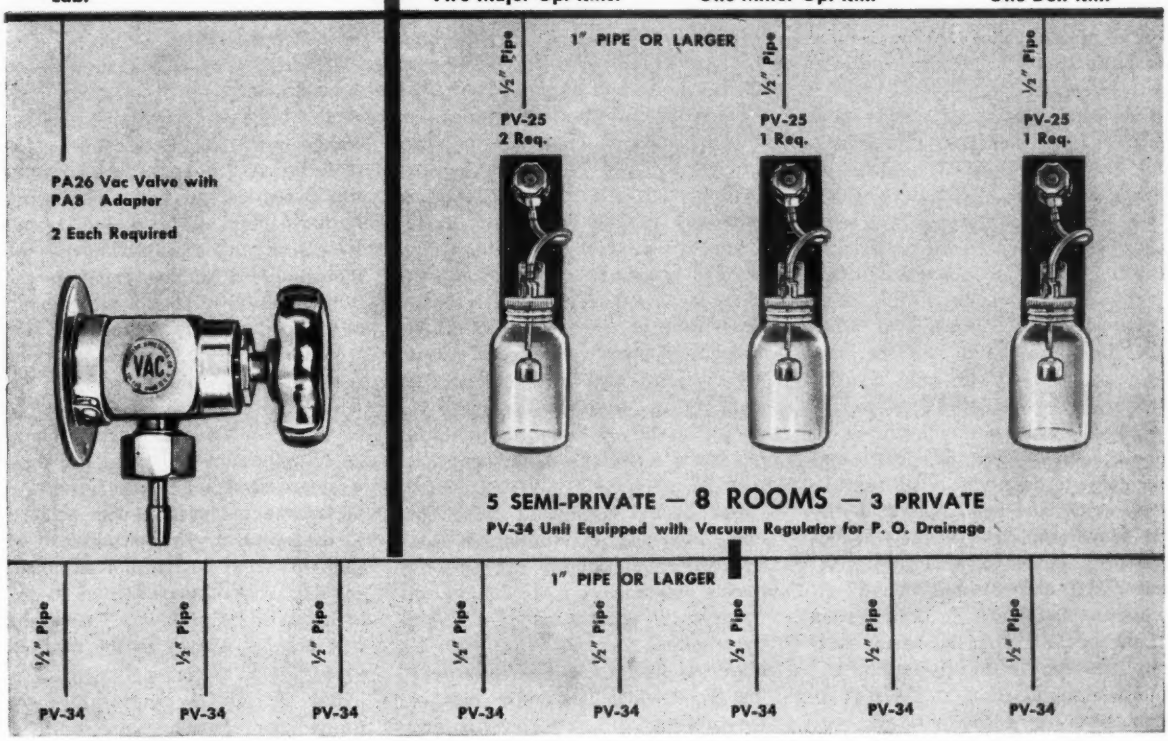

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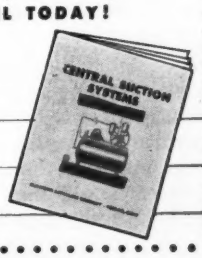

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Ghost surgery and fee splitting

■ THE INTERVIEW with Dr. Paul R. Hawley, director of the American College of Surgeons, published in the Feb. 20 issue of *U.S. News & World Report,* entitled "Too Much Unnecessary Surgery," was obviously designed both by Dr. Hawley and the magazine to shock as large a segment of the public as possible into awareness of the evils dealt with in the interview. These evils for the most part occur in what might be called the underworld of medicine and surgery as well as of those aspects of hospital administration which touch upon them. Such malpractices can exist only in a relatively small number of cases. On the other hand, the fact that they exist at all can only be considered as shocking.

What can hospital executives do about such things? The more mature among them will recall that the very evils scored so emphatically by Dr. Hawley in the interview . . fee-splitting, unnecessary surgery without check and without penalty . . were the basis for the organization of the A.C.S. This led to the hospital standardization program, actually a sound effort at the regulation of surgery rather than the regulation of hospitals.

It was speedily recognized that most bad surgery could not occur in a properly-conducted hospital, hence the standardization program. Now that the hospital organizations are themselves among the sponsors of the accreditation program, as it is now called, clearly it is more than ever necessary as a matter of self-respect for the hospitals themselves to act. Such action includes everything possible to eliminate the evils to which Dr. Hawley gave such vigorous publicity. This means strict enforcement of the checks whose operation is in their hands.

Adequate case records are of course close to the top in the system of checks on what goes on in the hospital. This is especially true in the case of surgery, since there is supposed to be a record for the perusal of the powers that be; the fact that, for example, healthy tissue was unnecessarily removed. The laboratory has to be on the job to make this evidence available, and the record has to be set down by a qualified person at the proper time, otherwise it may as well not exist. Fee splitting naturally does not ever become a matter of record, but every now and then it comes to the knowledge of the hospital administration in the roundabout ways travelled by such information. At such times there is no question about the duty of the executive and his board no matter how painful it may be.

But over and beyond these old evils, unpleasantly familiar at least by name, and happily not by any means common, it is to be hoped, there is the curious and disturbing thing called ghost surgery. This is a kind of offshoot of the overpowering greed which lies at the base of fee-splitting. It seems that the idea is for the patient's doctor, not actually up to the supposedly indicated surgery, to hire a "ghost." This individual slips into the operating room at the last moment, with the patient duly anesthetized, does the surgery and slips out. The patient must assume that his own doctor did the surgery, his doctor renders the bill, and the "ghost" never appears in the picture. That is the way it is done. Dr. Hawley referred to it as happening, chiefly in the larger cities and in what he referred to as unethical hospitals. It may be recalled that a year or so ago one of the women's magazines shocked the country by publishing an article on the subject. So, in spite of the fact that most hospital people would stand aghast at the very suggestion that such things can be, "ghost surgery" evidently does happen.

It can be asserted at once that it can't possibly happen in a good hospital, the kind referred to in the interview by Dr. Hawley, who declared that "the great majority of the hospitals are as clean as a hound's tooth." The reason it can't happen in such a hospital is that the whole set-up for the "ghost" is one which the clean and honest record of a good hospital could not and would not permit. The operating-room personnel, the anesthetist, the whole surgical team, would have to be in on the falsehood taking place. It is impossible to imagine their tacit acquiescence in the fraud. No doctor staging such a spectacle . . so dangerous to the patient and so shameful in all of its implications . . could possibly be permitted to remain on a hospital staff, once the fact became known to the authorities.

But Dr. Hawley says that these things are actually happening, in however few hospitals and involving however few people. Certainly then, the hospitals, for their own protection and that of their patients, must do everything possible to put a stop to such unholy masquerades, so much more like the incredible stories of witchcraft and medieval sorcery than the clean, safe and scientific medicine of this, our time.

If the new sponsorship of the accreditation program had no other object than the complete elimination of such frauds, it would be worthy of the warm support of all decent hospital people, as of all ethical medical men. ■

Main Kitchen, Mid-State Baptist Hospital, Nashville, Tenn.

They've "QUARANTINED" NOISE in this kitchen

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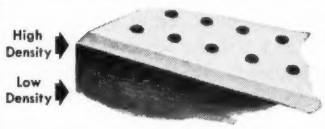

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Nursing Service | Central Supply

Seven distinct trends in nursing education

■ SEVEN DISTINCT TRENDS in nursing were listed Feb. 13 in Chicago by Helen Nahm of the National League for Nursing for the American Protestant Hospital Association. Miss Nahm is director of the department of baccalaureate and higher degree programs for the league.

These trends were identified as follows:

1. The trend toward long range planning on local, state, regional and national levels for the improvement of nursing service and nursing education.

2. The trend toward a clearer statement of purposes of educational programs which prepare for nursing at various levels of responsibility.

3. The development of greater concern about the experiences which students have in a school of nursing.

4. The trend toward better selection of students for programs offered at various levels.

5. The trend toward improved methods of evaluating the effectiveness of a school of nursing.

6. The trend toward a more careful analysis of the costs of nursing education.

7. The trend toward more cooperative planning by all groups concerned with the improvement of nursing service and nursing education.

Long range planning . . "During recent years," said Miss Nahm, "many states have made surveys to determine nursing resources within the state and to estimate nursing needs, both present and future. Not only have estimates been made of the numbers of nursing personnel which will probably be needed . . professional nurses, practical nurses and auxiliary workers . . but also of their qualifications and preparation.

"These estimates are based," continued Miss Nahm, "on present day trends in health and medical care and also upon an analysis of tasks which are now being performed by nursing personnel with varying degrees of preparation.

"We know, for example, that more patients are coming to hospitals than ever before. However, the hospital stay is shorter and a much larger proportion need highly skilled care during the stay. The nurse carries out many complex procedures formerly performed by the physician.

"Because of the short hospital stay there is greater need than in previous times to teach the patient or the family the tasks they may have to perform after the patient goes home. To do this the nurse needs new knowledge and skills.

"Formerly she could give most of the nursing care herself. Now a large proportion must be delegated to others. To be an effective leader of a team of workers giving care to a large group of patients requires knowledge and skill far beyond that needed in performing tasks herself.

"Not too many years ago we were not concerned about the need for nurses in tuberculosis and mental hospitals. Today it comes as something of a shock to hear that there is one professional nurse to three beds in general hospitals, one to 13 in tuberculosis hospitals and one to 61 in mental hospitals. Almost 54 per cent of hospitalized patients are in mental hospitals and only 5 per cent of professional nurses are contributing to their care.

"In analyzing trends we find that there are more than 300 nurses per 100,000 population in some of the New England states and between 75 and 124 per 100,000 in a number of southern states," continued Miss Nahm. She took her figures from *Facts About Nursing,* 1952 edition, a booklet of the American Nurses Association, 2 Park Avenue, New York City.

"Similar differences exist between larger cities and rural areas within each state. In many sections of the country steps have been taken to correct these inequities. Some states have appropriated money to make it possible for graduate nurses to secure additional preparation in clinical nursing areas or in administration, supervision or teaching, or for a larger number of students to enter basic nursing programs.

"Hospital and collegiate schools in increasing number are arranging for their students to have rural hospital experience. Experimentation is going on in many sections of the country to see whether it is possible to prepare a competent bedside nurse in less than the traditional three-year period.

"Basic and advanced nursing programs in colleges and universities are being markedly improved and purposes of these programs are being more clearly defined. In the advanced programs far more attention is being given to the preparation of nursing service personnel than was true in the past.

"As members of the accrediting service staff traveled across the country during the summer of 1952 to conduct a series of regional conferences, they were impressed with the planning which was being done in many places to improve nursing service and nursing education. There were discussions of how several states within a region could plan and work together and how schools or nursing could help each other.

"At the close of each conference it was recommended that additional conferences be held in 1953 and that other groups, including hospital administrators and physicians, be invited to attend such conferences. Plans are now going forward for another series of conferences incor-

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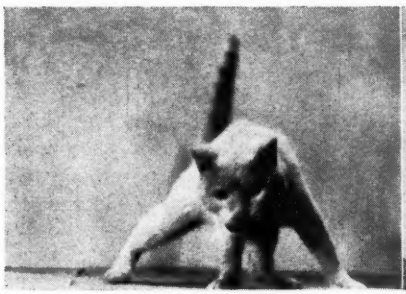
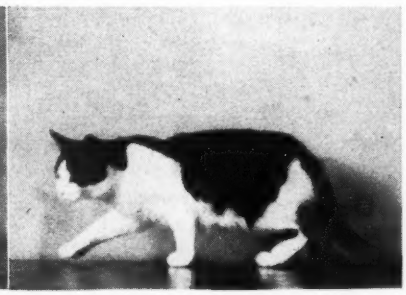


Cat treated with streptomycin is ataxic.



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porating the suggestions made in 1952. We very much hope that hospital administrators will be well represented.

"We believe that it is essential that there be joint planning between professional groups concerned with improvement of nursing service and nursing education as well as within the nursing profession itself."

Clearer purposes . . "There is general agreement today that a number of groups of workers are needed in nursing with varying levels of preparation," continued Miss Nahm. "According to the 1952 edition of *Facts About Nursing,* 73,325 nurses were employed in 1951 in administrative, teaching and supervisory positions in hospitals and schools of nursing and an additional 134,793 (includes 23,772 part-time) were employed in general duty positions. In addition a total of 167,977 practical nurses and attendants were employed. What do these figures mean for schools of nursing?

"In the past it was taken for granted that all schools of nursing could prepare professional nurses. But what of the job of the professional nurse today? What does she need to know? What should she be able to do? What kind of person should she be? In a limited period of time I can suggest only a few things which need to be given serious consideration in preparing a professional nurse."

What knowledge . . and understandings should she have?

"1. Understanding of the structure and functioning of various parts of the body needed in carrying out nursing procedures safely and skillfully.

"2. Understanding of aseptic technique in order that she may carry out complicated nursing procedures safely.

"3. Understanding of the effect of common drugs.

"4. Knowledge of symptoms which indicate that life may be in danger.

"5. Understanding of the emotional problems of patients . . the fears and tensions which accompany sudden and long term illnesses."

What skills . . should she have?

"1. Skill in observing symptoms . . physical, mental, emotional.

"2. Skill in reporting to others in speech and writing.

"3. Skill in carrying out nursing procedures.

"4. Skill in listening, reassuring, explaining.

"5. Skill in teaching patients, families, non-professional workers.

"6. Skill in working with physicians, other nurses, non-professional workers and others contributing to patient care.

What kind of person . . should she be?"

"1. Concerned about the welfare of her patients regardless of age, sex, creed, economic status.

"2. Able to subordinate immediate personnel desires and to work cooperatively for the welfare of all.

"3. Respect for herself and her own contribution.

"4. Respect for her profession and its contribution to human welfare."

Obviously referring to schools of nursing which have not measured up to the accreditation standards, Miss Nahm observed that "Though it is recognized that changes which have disrupted long accepted educational patterns in schools of nursing have exerted hardships on a number of institutions, we have many evidences which indicate that the readjustments which are now taking place are long overdue and that the schools which are making such readjustments are genuinely proud of their achievements."

Student nurse experiences . . "Schools of nursing are becoming increasingly aware of the fact that all experiences which students have in a school of nursing affect, for better or worse, the understandings, skills and attitudes which they will develop," continued Miss Nahm. "In educational institutions, general as well as professional, the curriculum is being defined as a series of experiences through which students learn, rather than a list of courses which are taught in the classroom."

Miss Nahm pointed out that student nurses have experiences in hospital divisions and outpatient departments, in classrooms and laboratories, in the residence and in the community.

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The Patient

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The Manager

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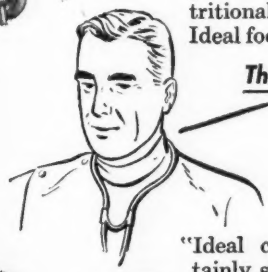
The Doctor



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The Nurse

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"Some, in the course of a nursing program, have experiences in a number of hospitals and a few have experience in a public health nursing agency as well. Wherever students may be their learning is affected by the skill of their teachers, the facilities which are available for instruction, the kind of nursing care which is being given, the attitudes which head nurses, staff nurses, doctors, residence directors and all others exhibit toward them.

"Schools of nursing are becoming increasingly aware of the fact that students cannot learn to give good bedside care to patients unless they have opportunities themselves to give such care. They know that students cannot develop proficiency in carrying out procedures safely and accurately unless they have time to practice under adequate supervision before being left alone with heavy responsibilities for patient care.

"They know that students cannot develop understanding of the emotional problems of patients unless they see such understanding displayed by graduate nurses, physicians and others. They realize that it is difficult for students to develop desirable attitudes toward their own profession unless they come in contact with graduate nurses who have such attitudes. . ."

Better student selection . . Concern was expressed by Miss Nahm over the large number of student nurses who drop out before completion of the course.

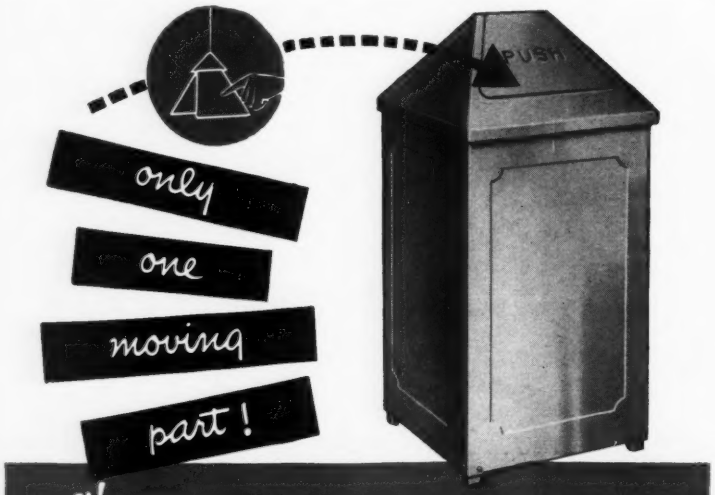
"Ninety per cent of the schools now use pre-nursing tests in student selection," said Miss Nahm. "Fifty-two per cent select from the upper half of the high school graduating class and 32 per cent from the upper third. These figures indicate that the majority of schools are making efforts to improve their selection procedures.

"Sixteen per cent make no requirement about high school achievement. Seventy-eight per cent of the schools admit students of less than 18 years of age. Perhaps the heavy drop out rate is related in part to the immaturity of entering students and the exceedingly complicated hospital situations with which they are expected to cope not many months after admission.

"Of increasing concern to many states and to some schools within each state are the low scores which graduates of professional schools make on state board examinations. A study made by the department of measurement and guidance of the National League of Nursing shows that there is a definite relationship between scores on aptitude tests given at the time of admission and scores on state board examinations taken after graduation. . ."

Evaluating schools of nursing . . "Schools have been increasingly aware of the fact that all of the quantitative standards of excellence can be present without necessarily having a good school," remarked Miss Nahm.

"General education institutions, as well as schools of nursing, have more recently centered their attention on the importance of qualitative rather than quantitative standards. A good faculty, for example,



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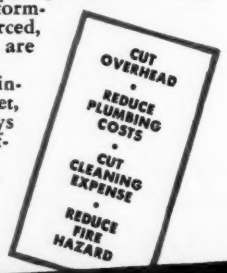

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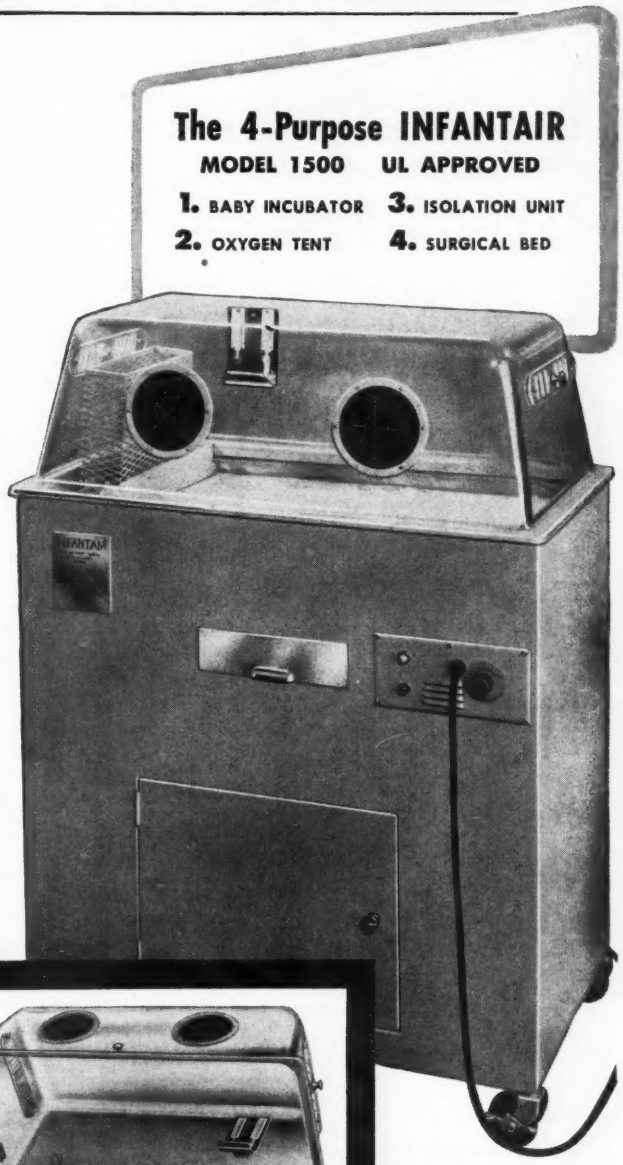

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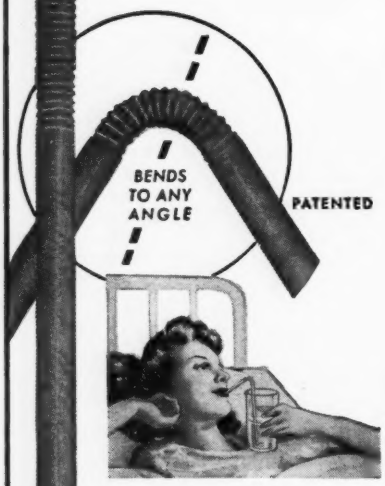

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"Perhaps of even greater importance than the efforts now being made to evaluate qualitative factors is the trend toward the evaluation of the effectiveness of a school in terms of the success of its graduates. . .

"In the program of full accreditation, the accrediting service of the National League for Nursing operates on two assumptions which we believe are fundamental both to the freedom of a school and to its best development. One is that the program of a school shall be evaluated in relation to its own statement of philosophy and purposes. The second is that a program shall be evaluated in relation to its over-all strengths and weaknesses rather than in relation to specific items. . ."

Conclusion . . Miss Nahm noted in closing that the hospital administrators, the medical profession and the nursing profession are working together on both a national and regional scale and solutions to problems are being worked out in cooperation. Miss Nahm saw this spirit of cooperation leading to a solution of present problems of nursing service and nursing education. ■

Tell Your Representative . . .

continued from page 18

that any plumber who worked the same hours as a physician could earn approximately the same income and that the local public utilities charged nearly as much to make an emergency call as the doctor does for most house calls. The doctors also explained that profes-

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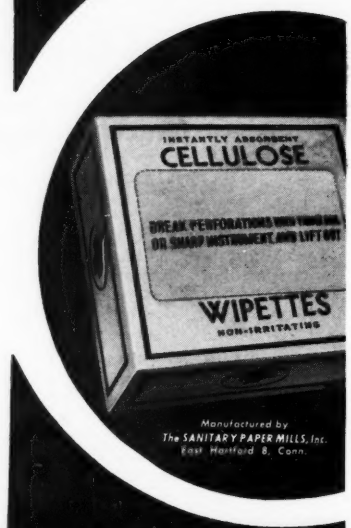

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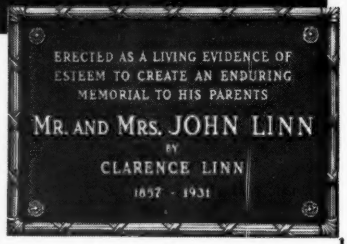

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sional fees are based on a schedule that will allow a physician to pay his overhead and earn his own living. Little was accomplished to change our visitor's belief. The public does not understand the present method or the complicated combination of circumstances that determines professional charges. It is my personal opinion that a system of professional charges readily comprehensible to the public would constitute a great advance in medical public relations.

One of our guests was an insurance agent. It was his enthusiastically expressed opinion that doctors and hospitals should not enter the field of insurance. In reply it was quickly pointed that the primary interest of doctors and hospitals is not in the insurance business but in the ability of the patient to pay his hospital and doctor bill as quickly and painlessly as possible.

This means the voluntary prepayment method best exemplified by Blue Cross and Blue Shield. Both sides agreed that private insurance companies are not now in a position to offer an acceptable substitute for the Blue Cross and Blue Shield organization on the scale which is an absolute necessity in the United States today.

Another problem . . that was prominent in the discussion is a strongly local one. Yet it indicates the method in which difficulties can arise between hospitals and legislative bodies. During the last session of the Iowa Legislature, the Iowa State Licensure bill was the subject of much heated discussion. The nature of that discussion was such as to work a considerable disservice to the hospitals and their association in this state.

Briefly the licensure bill was originally drawn up by a duly appointed committee of the State Hospital Association and presented to the legislature. The legislators accepted the bill as it was presented and it became a law. As the law came into effect a number of hospitals found that they did not like its provisions nor the administration of the law and bitterly assailed their own representatives for concurring in the passage of such a bill.

Understandably the legislators

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were confused by this turn of events and cherish a considerable resentment against the hospitals. The State Hospital Association is now making a concerted effort to work out this problem with the other agencies involved. Our guests indicated that the legislature urgently wants and expects a clear cut solution that will avoid a repetition of the last session's unpleasantness.

This incident aptly illustrates the great responsibility of hospitals to counsel wisely among themselves and to adjust their own internal differences of opinion before presenting recommendations on policy matters affecting hospitals to any outside body.

In today's unremitting effort to gain from the public sympathetic understanding of the peculiar problems of providing hospital care our elected representatives deserve to know well their doctors and their hospitals. First-hand contact with the hospitals and the profession will at the very least prove sincerity of purpose. Better understanding must inevitably lead to greater sympathy with the aims and accomplishments of American medicine today. The visit of the two legislators was very indicative to me of the topics to be included in any presentation of this nature. The most painstaking effort to inform your representatives will be well rewarded . ■

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To the Author . .

continued from page 66

selling point of the fact that his policy's $4 daily allowance for normal birth is increased to $8 for twins and $12 in the case of Caesarean section. With a 10-day limit (same as Blue Cross) this makes an $80 limit for twin birth and $120 for a Caesarean, and these sums are compared unfavorably with the Blue Cross limit of $50. Yet the Blue Cross $50 exceeds the insurance company's $40 limit for normal birth, and, as for the others, Caesareans occur four out of 100 times and twins only once in 100 times!

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point of comparison, as to relative value per dollar expended, is "what percentage of income is paid back in benefits." This information is published annually for all insurance companies and all Blue Cross and Blue Shield Plans, in the National Underwriter Company's "Argus Chart" and in other publications. The current Argus Chart shows that the young salesman's company returned 48.8 per cent of its income in the form of benefits in 1951. The same publication shows that your Blue Cross Plan returned 88.2 per cent and your Blue Shield Plan 78.8 per cent, in the same year. The national averages for Blue Cross and Blue Shield are slightly higher than these figures.

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Mrs. X, you ask "honestly, which is the better deal?" I leave it to you. Honestly, which *is* the better deal?

RICHARD M. JONES, Director,
Blue Cross Commission of the
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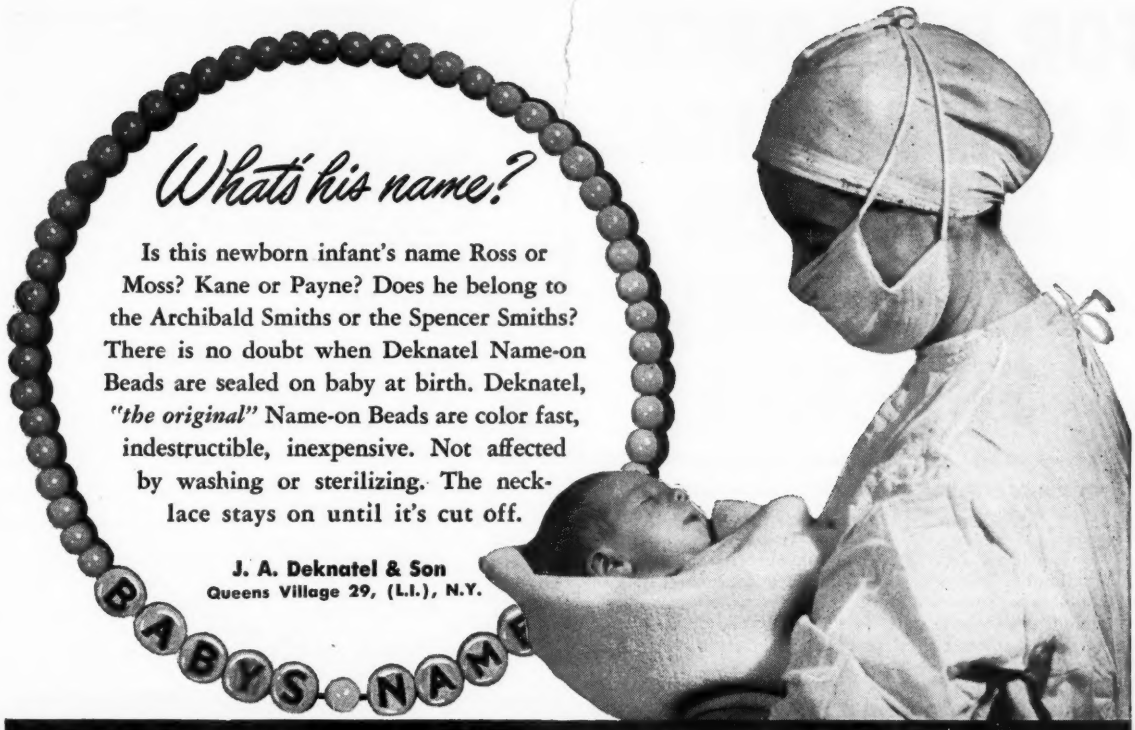
Rev. Beebe elected head of chaplains

■ REV. L. E. BEEBE, chaplain of the Federation of Churches of Christ, Albany, N.Y., was elected president of the Association of Protestant Hospital Chaplains Feb. 13, 1953 at the annual meeting in Chicago. He succeeds Carl J. Scherzer, D.D., chaplain, Protestant Deaconess Hospital, Evansville, Ind.



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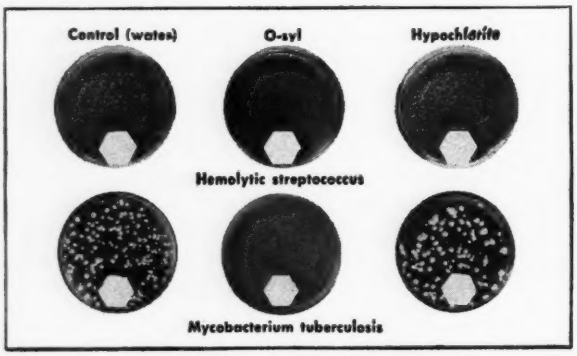

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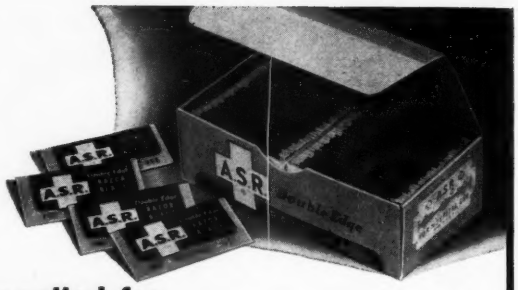

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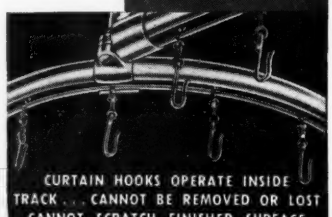

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Diary

continued from page 60

not transcribed. Secretary has had flu, wife has had flu, he has had flu. Apologizes for having had flu. (And all the time I thought he was in Florida.) Gets all het up about sterile water tanks not being sterile. Not being put in any more. Public health departments don't approve. If I want my surgical supervisor to design surgery it's O.K. with him. He does some coughing. Sounds mad. Perhaps calling him twice within a half hour did it.

I tell Ev that the consultant is supposed to know more than I do and I will probably agree with him and start an educational campaign locally.

17 When the sharp eyes and ears of Miss Cafferty have made their appraisal we have the feeling that our nursing school has made the grade this time. Called architect: we will go into "flasking."

24 After conferences with the plumbers, construction foreman and Dr. Jenkins we settle the sterile water supply problem for the cystoscopy room and the operating room where he will do resections. This time we saved some money.

26 With board members Arthur Reppert and Oscar Biklen I visited Mr. Sater's widow and then the farm left us in the will. Both Mrs. Sater and the tenant impressed us as being very nice people. There are some differing viewpoints about who owns the machinery, and some other details.

That night Mr. Biklen and I talk with an attorney on the case. We find that we have received the best farm, and probably have the only tenant who will give any trouble; that Mr. Sater gave all his tenants ten-year leases just before he died; that he willed half his estate to his wife, and that if the balance isn't half, the farms will be sold to make it up; that the court will recommend that the farms be operated by the new owners until the appraisal is made and the case settled; we will probably get it settled in about two years. So there goes the hope we had of starting construction on the new kitchen and laundry this year.

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What training shall we require of our hospital pharmacists?

by Sister Mary Bernice, S.M. St. Mary's Hospital • St. Louis University

■ EXPERIENCE has brought with it the realization that the word "pharmacy" is a broad term, embracing as it does a number of highly individualized specializations in somewhat the same manner as the medical profession with its subdivisions of numerous specialties. Once we have recognized this aspect, the realization necessarily follows that the basic preparation for the profession of pharmacy is scarcely adequate for each of the specializations which require intensive, individual, and pertinent direction and development.

If pharmacy is to be recognized as professionally equal to the allied branches of the medical profession, its educational requirements must parallel theirs. Many educators in pharmacy are of the opinion that a four-year academic program leading to the bachelor of science degree in pharmacy is too crowded, and that the students participating in it do not obtain an adequate education in general pharmacy nor the fundamental knowledge requisite for the various specialties of pharmacy.

Consequently, educators are advocating at least five years . . preferably six years . . as a basic preparation period toward a B.S. in pharmacy. This proposal would make possible one year of liberal arts as pre-pharmacy education, and/or one year in which fundamental principles of the various specialties of pharmacy could be included as electives.

This course for hospital pharmacy . . might include two lecture hours per week and six hours of laboratory per week in a qualified hospital pharmacy with the lecture courses covering general principles of the following topics: history and development of hospitals including hospital pharmacy; organization of hospitals including staff organization; general understanding of different types of hospitals and what constitutes their main differences; an understanding of hospital association ethics and standards of hospital practice; lines of authority and relationships between the pharmacy and other departments of the hospital, e.g., the medical and nursing staffs, the administrator, the therapeutics committee, etc.

Physical facilities and arrangement of hospital pharmacy; special regulations, e.g., those concerning alcohol, narcotics, barbiturates; stills, their purchase, destruction, and discontinuance; purchasing; budgeting; storage of all items stocked in the pharmacy department; stock arrangement; public relations; hospital procedures; pharmaceutical manufacturing and dispensing, and the multitudinous aspects of interdepartmental relationships.

It is of vital importance . . that someone or some group of hospital pharmacists formulate in detail a course in hospital pharmacy. Until recently, comparatively little had been written on this subject. Remington's Practice of Pharmacy, tenth edition, has a chapter devoted to hospital pharmacy. The committee on education of the American Society of Hospital Pharmacists, during the year in which Herbert L. Flack was chairman (1950), developed a Proposed Syllabus for the Course of Hospital Pharmacy Administration. These would prove profitable references in compiling a text on hospital pharmacy.

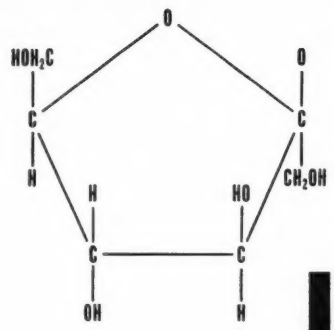
Before any specific courses in hospital pharmacy were offered in schools of pharmacy, knowledge of principles specifically applying to hospital pharmacy administration was gained the hard way . . by arduous self efforts or by apprenticeship methods. Former educators in the hospital field did not always understand their hospitals' pharmacy problems and educators in pharmacy were not fully cognizant of the specific needs of the hospital phase of pharmacy.

Due to lack of organization, insight, and foresight, the needs of and progress in hospital pharmacy received little consideration. There were those hospital pharmacists who themselves administered well-organized departments, but were unaware of the plight of their less fortunate colleagues. At times, deficiencies were recognized but little could be done about them. There were those, also, who were unaware of their own shortcomings, or if aware, lacked the initiative to impress both administrators and educators with the import of hospital pharmacy.

The organization of the American Society of Hospital Pharmacists, whose members work together to promote the interests of hospital pharmacy, is one of the greatest contributing factors toward the advancement of hospital pharmacy.

Need coordinating text . . Not only is there a need for a text on fundamental principles of Hospital Pharmacy, but there exists a real urgency for a text to coordinate practical experience with the academic course leading to an M.S. in hospital pharmacy. Such a text is

This paper was read Dec. 30, 1952 before the sub-section on pharmacy of the American Association for the Advancement of Science at St. Louis, Mo.



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almost an essential stabilizing factor in the hospital pharmacy internship program. This text should include principles of hospital pharmacy administration organization, advanced procedures and techniques, and other planned educational projects.

It does not seem possible to separate the period of practical experience from the academic program unless or until such a program can be taught in the laboratory of the schools of pharmacy. However, if the entire practical teaching were done exclusively in the laboratory, the cost of such a program would be prohibitive and, not only that, the teaching would be less effective.

This has been proved in nursing schools which at one time deviated from bed-side nursing teaching to give emphasis to classroom instructions. The error of the latter method was detected in due time and intensive bedside nursing teaching or clinical instruction now has been resumed. The Association of American Medical Schools and the American Medical Association also have recognized the importance of clinical instruction for medical students, so much so, that medical schools cannot receive approval unless intimately connected with some hospital which it can use for teaching purposes.

During the two years required for an M.S. in hospital pharmacy, the practical application of knowledge should be integrated with the academic courses in a manner similar to that plan followed both by schools of nursing in bedside nursing techniques and medical and dental schools in their internship programs.

Define terms . . It is important that at this time the American Society of Hospital Pharmacists clearly defines what is to be understood by the term "hospital pharmacy internship" in order to assure the establishment of sound programs, since it is easier to prevent than to correct errors.

It seems that the term "internship" should be used to designate only the graduate program and that some other term, perhaps "student-internship," should be used for the undergraduate requisite, since the internship should be experience over and above that required for state board examinations including experience requisites.

Hospitals should be required to meet certain standards in order to qualify for the hospital pharmacy internship program, just as they are expected to meet stated requirements before authority is given them to offer internships and/or residencies in the medical profession.

Hospital pharmacies offering these programs should conform essentially to the requirements of the Minimum Standards for Hospital Pharmacy. The American Society of Hospital Pharmacists should determine the degree of excellence required. Educators in the field of pharmacy and practicing hospital pharmacists should form a council or commission jointly responsible for advanced education in the field of hospital pharmacy which should be authorized to examine and to approve hospitals for internships and residencies. Experience needed for state board examinations could be obtained in hospital pharmacies having a lower degree of attainment than that required for internships and residency programs.

This brings to mind an apparently irrelevant, but nevertheless important point in the education of the hospital pharmacist, namely, that it would be well for state boards to require a certain degree of excellence from retail prescription pharmacies as qualifications needed for a setting in which experience for state board examinations could be obtained, not only by those pharmacists who may later wish to enter hospital pharmacy, but also by all applicants for state board examinations.

The academic requirement of the M.S. degree in hospital pharmacy for the major course should consist of approximately 18 hours in the following or other related subjects: Hospital Pharmacy (3 credit hours); Hospital Organization and Management (4 credit hours); Seminar in Problems of Hospital Pharmacy Administration (3 credit hours); Advanced Pharmaceutical Preparations (3 credit hours); Personnel Management (3 credit hours); Introduction to Statistics (3 credit hours). The minor should be chosen from various related subjects, e.g. Pharmacy, Bacteriology or Chemistry, consisting of 12 semester hours of upper division courses, and allowing six credit hours for the thesis. It would seem practically essential that a qualified hospital pharmacist teach these courses.

The practical experience . . should include hospital orientation in a program that embraces points similar to the following: contacting the admitting office to witness the registration and admission of patients; contacting nursing divisions to observe how rounds are made with the physicians; how orders for medications and prescriptions are written; the arrangement of medicine cabinets, including narcotics and barbiturate cabinets; the administration of medications to patients, including intravenous, intramuscular and hypodermic medications; the method of recording administered medications, including the recording of narcotics; the procedure regarding medicine charges which are sent to the pharmacy; the effects of medicine on patients; nursing conferences, etc.

Tours should be conducted through the surgery division, the laboratory, and the pathology department. At least one major operation, as well as an autopsy, should be witnessed.

The institution's heat, light, power, and maintenance plants should be visited to enable the students to gain a general knowledge of the functioning of every division, and how all contribute toward the achievement of the common good and goal of the institution. Field trips to other hospital pharmacies followed by written reports on them might be included in the program.

Performance of every type of work in pharmacy should be required, including the washing of bottles and housekeeping to a degree necessary to familiarize the students with such procedures. Since the students are preparing themselves for their future work as qualified hospital pharmacy administrators, it is essential that they know every detail which will contribute to the administration of a well-organized department.

The residency, combining another year of practical experience with

further academic work, would lead to the degree of Doctor of Science in Hospital Pharmacy.

In hospitals offering these programs, the pharmacists should bear in mind constantly and conscientiously that although it is their weighty responsibility to prepare the students thoroughly for their future work, service to the patient must never be sacrificed for the sake of education. The primary purpose of a hospital . . and, therefore, of a hospital pharmacy . . is to give efficient care to all patients of the institution. This principle must direct necessarily the teaching program in all of its aspects.

The promotion of advanced pharmacy education calls for the proper integration and coordination of all phases of the program. In the ability or inability to accomplish this lies the success or failure. ■

Books

THE FIRST HUNDRED YEARS OF THE MOUNT SINAI HOSPITAL OF NEW YORK 1852-1952. By Joseph Hirsh and Beka Doherty. Published by Random House, New York.

■ ONLY OCCASIONALLY DO the historians of an institution attempt to weave its history into the rich tapestry of the civilization which gave it birth; rarely do they succeed. Yet Hirsh and Doherty, in writing the story of "The First Hundred Years of the Mount Sinai Hospital of New York," have attempted to do just this; and they have done it very well indeed.

They succeed in bringing to life the New York of which Mount Sinai has been an integral part, and in parading before us, in all their richness and complexities, the interrelations and the give-and-take between the City and the Hospital.

Particularly is this true of the earlier years. We see, for example, the "filth and poverty" that was the setting of the outbreak of Asiatic cholera in 1849, as well as the all-pervading fear it inspired . . and the effects of both on the Hospital. We see the men and women come to life as they struggle to found a voluntary hospital in the midst of a severe economic depression. We see, in quick review, the medicine of the mid-century: the "diploma mills" that were the medical schools; the cultists; the systems; in fact, all the chaos that was medicine then, as well as the first attempts of American physicians at scientific investigations and instruction. And we see these not only as they were in the City, but also as the Hospital reacted to them. Nevertheless, in the midst of all this . . and of superstition too . . the Hospital's Medical Board advised "that . . . . the simple fact of a disease being contagious should not preclude its reception into an hospital . . . . ." (Result: admission of typhoid patients).

Established early, too, was another outstanding and till now unbroken tradition at the Hospital: the 1872 Annual Report stated that the Trustees intended "greatly to extend the sphere of its (the Hospital's) usefulness by the establishment of a clinique, contributing thereby to the advancement of medical science and aiding the student in the study of his profession."

With these traditions established not as beds on which to sleep, but as spring-boards from which to leap into the future, other fundamental steps were taken in rapid succession: separation of the various services in the inpatient and outpatient departments; establishment of the School of Nursing; creation of a District Medical Service; the recognition of the newly-rising specialties; the establishment of the laboratory, the Social Welfare Department and the Hospital's Fellowship Fund. These were some of the early major steps, some of the "firsts." But there were others, year after year in unbroken succession on through the Goldwater era, the immediate past and the present: the first Psychiatry Clinic, the famous Clinical-Pathology Conferences, the Consultation Service, the vast amount of significant research in almost every field, the new "Carver Houses project . . an experiment in both medicine and sociology."

All these had their beginnings and their roots in the concepts of community service which have been inseparable parts of the lives of the many who have been Mount Sinai: the trustees, the physicians, the patients. These men and women parade before us, not as stick-figures drawn against a background in monotone, but as individuals living in a world with ever-expanding horizons and in a society of almost uninterrupted crises. These are the men and women who have contributed their varying shares both to the expansion of the horizon and to the crises, and who, in turn, have been molded by their handiwork; but they are also the men and women who have had flashes of vision (frequently repeated) which have helped illuminate the way for the rest of us.

This history of the Mount Sinai Hospital can be recommended not only to hospital administrators but to all who are interested in the problems of health and social welfare.

Reviewed by
SIGMUND L. FRIEDMAN, M.D.,
Director Division of Professional and Administrative Practices
Health Insurance Plan of Greater New York

M.R.L.'s to convene next month at U. of Indiana Medical Center

■ AN ADVANCED WORKSHOP for Medical Record Librarians will be held at the Indiana University Medical Center in Indianapolis, April 27 — May 1, 1953.

Requirements for registration for the workshop are that the applicants be registered record librarians, be employed in hospitals of 200 or more beds, and have an office staff of at least five under their supervision. Registration will be limited and applications must be on file by April 1.

Further information can be obtained by writing to Miss Doris Gleason, R.R.L., Executive Secretary, American Association of Medical Record Librarians, 510 North Dearborn Street, Chicago 10, Illinois. ■

The administrator's responsibility in food service

by Mrs. Cora E. Kusner Director of Dietetics • Colorado State Hospital • Pueblo, Colorado

■ THE FIRST THING I am going to say may startle some of you a bit . . I do not think that the hospital administrator ought to burden himself with any *direct* responsibility for the hospital food service! I *do* believe that he must select an individual in whom he can have enough confidence to delegate that responsibility.

The administrator's responsibility is four-fold: first, for building an organization; second, for defining the objectives of that organization; third, for establishing the policies through which that organization is to function, and, fourth, for fostering the development and professional growth of the individuals whom he has selected to be the key people to carry out his plan.

The problem of developing individuals is the same on any level. As dietitians we are learning that we cannot afford to sit back and say, "We have such poor employees!" A large part of our job is training . . learning to minimize the faults, and make the most of the ability, of the human beings available to do our work. Administrators, I am sure, have the same job of training to do on the professional level, because there are just not enough mature, experienced, capable people to go around, in more fields than dietetics.

Specifically. . . what does a professional dietitian hope for in her relationship with the administrator under whom she works?

First, an honest clear statement of the established policies of the organization and an understanding that when a problem arises she can come to him for discussion and clarification of whatever policies might affect her judgment in solving that problem.

These problems may come up with regard to many phases of her work. Questions regarding the budget must be answered in the light of some general policy regarding the desired level of meal cost. Personnel practices need to be uniform for all departments, and clearly defined. Matters of public relations frequently require a knowledge of hospital policy. There may be some question of policy regarding her own salary which she will need to understand. No good working relationship can be developed without mutual understanding.

The second thing a dietitian hopes for is inclusion as one of the professional team concerned with care of the patient. She realizes that she must *earn* her professional status, but the attitude of her administrator can go a long way toward making that possible. Such courtesies as introductions to new staff members and invitations to participate in staff meetings will help her establish herself.

Third, she hopes for realistic budgeting for adequate trainable help. Just so long as the food service is expected to function with the lowest paid, poorly selected dregs of all the applicants for jobs, for that length of time will there be inefficiency, high turnover, waste of food and dissatisfaction with the food service.

Budgeting also for clerical and stenographic assistance is needed. Is your dietitian doing her own typing? Do you expect her to do the bookkeeping? If you do, you are probably paying about twice what those services are worth, and at the same time keeping her from doing the jobs for which she is trained. A good dietitian welcomes a periodic evaluation of her work with honest censure or commendation, and guidance toward improvement or greater achievement as the case may be.

Finally, any dietitian wants a physical plant which is maintained and improved with the same care as any other department of the hospital.

The critical appraisal of hospital food service has been gathering momentum for several years. There was a time when patients accepted the fact that what they got to eat in the hospital was just part of a difficult experience. Employees received free meals as part of their pay and believed it was their privilege to "gripe." Few hospitals really knew what their food cost them.

Then came the growing knowledge of nutrition and the use of food as a therapeutic measure; a realistic attitude toward remuneration of employees and the policy of full pay in cash and pay cafeterias or some other method of selling meals, and rising costs which made cost accounting imperative. Food service not only gained professional status, but became "big business" as well.

Our profession has had to grow and broaden our interests and training, to cover all the aspects of the dietitian's job as it is commonly laid out today. Basically the dietitian is concerned with adequate nutrition for both well and ill. This involves the scientific use of food as a therapeutic measure; a job of nutrition teaching, and budgeting of time to permit close contact with patient, doctor and nurse. But she must also *produce* the food, and this involves skill in cookery, personnel management, a still bigger teaching job, sometimes purchasing, and always cost control.

continued on page 97

This paper was read before the annual meeting of the Kansas Hospital Association.

monthly menus hm ... April 1953

H = house (normal or general) diets
S = soft diets
P = personnel menus

		Wed. April 1	Thurs. April 2	Fri. April 3	Sat. April 4	Sun. April 5	Mon. April 6	Tues. April 7	Wed. April 8
BREAKFAST . .	H	Pineapple Juice Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Kadota Figs Hot or Ready-to-eat Cereal Bacon Curls Toasted English Muffins - Jam	Tomato Juice Hot or Ready-to-eat Cereal Baked Egg Hot Cross Buns	Orange Slices Hot or Ready-to-eat Cereal Scrambled Eggs Raisin Toast	Fruit Nectar Hot or Ready-to-eat Cereal Sausage & Eggs Danish Coffee Twist	Blue Plums Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Grapefruit Half Hot or Ready-to-eat Cereal Omelet Toast	Prunicot Hot or Ready-to-eat Cereal Scrapple Cinnamon Toast
	S	Pineapple Juice Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Tangerine Juice Hot or Ready-to-eat Cereal Bacon Curls Toast	Tomato Juice Hot or Ready-to-eat Cereal Baked Egg Toast	Orange Juice Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Fruit Nectar Hot or Ready-to-eat Cereal Crisp Bacon Toast	Prune Juice Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Grapefruit Juice Hot or Ready-to-eat Cereal Omelet Toast	Apricot Nectar Hot or Ready-to-eat Cereal Bacon Curls Toast
	P	Pineapple Juice Hot or Ready-to-eat Cereal French Toast Jelly	Kadota Figs Hot or Ready-to-eat Cereal Bacon Curls Toasted English Muffns - Jam	Tomato Juice Hot or Ready-to-eat Cereal Fried Egg Toast	Orange Slices Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Fruit Nectar Hot or Ready-to-eat Cereal Sausage & Eggs Danish Coffee Twist	Blue Plums Hot or Ready-to-eat Cereal Blueberry Pancakes Sour Cream	Grapefruit Half Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Prunicot Hot or Ready-to-eat Cereal Scrapple Cinnamon Toast
LUNCH . .	H	Tomato Soup Hungarian Goulash Green Beans Fruit Salad Brownies a la Mode	Bouillon Curry of Chicken Fluffy Rice Stuffed Celery Strawberry Shortcake	Mongole Soup Tuna Fish Salad Baked Potato Vegetable Jackstraws Cherry Cobbler	Corn Chowder Shepherd's Pie Lima Bean Casserole Tossed Salad Greens Sponge Jelly Roll	Consomme Julienne Cranberry - Ham Slice Glazed Sweet Potatoes Fresh Asparagus Pickles - Celery Curls - Radishes Apricot Ice Cream Sundae Angel Food Pastries	Cream of Tomato Soup Braised Short Ribs of Beef Riced Potatoes Cole Slaw Cheese Apple Crisp	Vegetable Soup Cold Roast Beef Macaroni au Gratin Corn Relish Devils Food Peach Shortcake	Cream of Spinach Soup Braised Tongue with Mustard Sauce Stuffed Baked Potato Carrot Slaw Fruit Bars
	S	Tomato Soup Broiled Veal Pattie Bean Puree Vanilla Ice Cream	Bouillon Stewed Chicken Fluffy Rice Sponge Cake	Strained Soup Tuna Fish - Noodle Casserole Baked Custard	Strained Soup Broiled Beef Pattie Baked Potato Sponge Jelly Roll	Consomme Julienne Minute Steak Whipped Potatoes Asparagus Tips Apricot Ice Cream Sundae Angel Food Pastries	Cream of Tomato Soup Broiled Lamb Chop Riced Potatoes Apple Cheese Crisp	Strained Soup Cold Roast Beef Macaroni au Gratin Peach-Vanilla Pudding	Cream of Spinach Soup Fillet of Lamb Stuffed Baked Potato Royal Anne Cherries
	P	Tomato Soup Hungarian Goulash Green Beans Fruit Salad Brownies a la Mode	Bouillon Curry of Chicken Fried Rice Stuffed Celery Salad Strawberry Shortcake	Mongole Soup Tuna Fish Salad Baked Potato Vegetable Jackstraws Cherry Cobbler	Corn Chowder Shepherd's Pie Lima Bean Casserole Tossed Salad Greens Sponge Jelly Roll	Consomme Julienne Cranberry - Ham Slice Glazed Sweet Potatoes Fresh Asparagus Pickles - Celery Curls - Radishes Apricot Ice Cream Angel Food Pastries	Cream of Tomato Soup Barbecued Spare Ribs Mashed Potatoes Hot Slaw Cheese Apple Crisp	Vegetable Soup Assorted Luncheon Meats Macaroni au Gratin Corn Relish Devils Food Peach Shortcake	Cream of Spinach Soup Braised Tongue with Mustard Sauce Baked Potato Carrot Slaw Fruit Bars
DINNER . .	H	Roast Loin of Pork Riced Potatoes Braised Carrots Spring Salad Snow Top Apple	Swiss Steak Latticed Potatoes Pimiento Cauliflower Chiffonade Salad Norwegian Prune Pudding	Fillet of Red Snapper - Tartar Sauce Mashed Potatoes Diced Beets Shredded Lettuce Pineapple Delight	Roast Leg of Lamb Chantilly Potatoes Frozen Broccoli Mexican Salad Prune Whip	Hot Turkey Biscuit Sandwich Potato Flakes Fruited Gelatin Salad Mold Easter Cookies Spiced Punch	Roast Prime Ribs of Beef au Jus Hash Brown Potatoes Creole Celery Garden Salad Orange - Date Custard Pudding	Spanish Meat Balls Duchess Potatoes Fresh Spinach Mounds A-B-C Salad Pear au Gratin	Stuffed Roast Shoulder of Veal Creamed New Potatoes with Chives Harvard Beets Fruit Salad Chocolate Chip Spanish Cream
	S	Strained Soup Roast Beef - Gravy Riced Potatoes Creamed Carrots Snow Top Apple	Strained Soup Swiss Steak Bu. Potatoes Green Peas Norwegian Prune Pudding	Strained Soup Baked Whitefish Mashed Potatoes Beet Puree Orange Sherbet	Strained Soup Roast Leg of Lamb Chantilly Potatoes Bean Puree Prune Whip	Strained Soup Creamed Turkey on Toast Fruited Gelatin - Wh. Cr. Easter Cookies	Strained Soup Roast Prime Ribs of Beef au Jus Bu. Potatoes Baked Squash Orange-Date Custard Pudding	Strained Soup Broiled Beef Pattie Duchess Potatoes Spinach Puree Pear au Gratin	Strained Soup Stuffed Roast Shoulder of Veal Creamed Potatoes Beet Puree Chocolate Chip Spanish Cream
	P	Roast Loin of Pork Mashed Potatoes Braised Carrots Spring Salad Snow Top Apple	Swiss Steak Fr.-Fr. Potatoes Pimiento Cauliflower Chiffonade Salad Norwegian Prune Pudding	Fillet of Red Snapper - Tartar Sauce Mashed Potatoes Diced Beets Shredded Lettuce Pineapple Delight	Roast Leg of Lamb Chantilly Potatoes Frozen Broccoli Mexican Salad Prune Whip	Hot Turkey Biscuit Sandwich Fritoes Fruited Gelatin Salad Mold Easter Cookies Spiced Punch	Roast Beef Round - Gravy Hash Brown Potatoes Creole Celery Garden Salad Orange - Date Custard Pudding	Spanish Meat Balls Duchess Potatoes Fresh Spinach Mounds A-B-C Salad Pear au Gratin	Stuffed Roast Shoulder of Veal Creamed New Potatoes with Chives Harvard Beets Fruit Salad Chocolate Chip Spanish Cream

monthly menus hm ... April 1953

H = house (normal or general) diets
S = soft diets
P = personnel menus

		Thurs. April 9	Fri. April 10	Sat. April 11	Sun. April 12	Mon. April 13	Tues. April 14	Wed. April 15	Thurs. April 16
BREAKFAST . .	H	Baked Rhubarb Hot or Ready-to-eat Cereal Shirred Egg Toast	Sliced Oranges Hot or Ready-to-eat Cereal Poached Egg Toast	Bananas - Cream Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Apple Sauce Hot or Ready-to-eat Cereal Link Sausage Orange Bowknots	Prune Juice Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Grapefruit Half Hot or Ready-to-eat-Cereal Omelet Toast	Stewed Peaches Hot or Ready-to-eat Cereal 3-Minute Egg Whole Wheat Toast	Orange Half Hot or Ready-to-eat Cereal Scrapple Pineapple Coffee Cake
	S	**Cherry Nectar** **Hot or Ready-to-eat Cereal** **Baked Egg** **Toast**	**Orange Juice** **Hot or Ready-to-eat Cereal** **Poached Egg** **Toast**	**Bananas - Cream** **Hot or Ready-to-eat Cereal** **3-Minute Egg** **Toast**	**Apple Sauce** **Hot or Ready-to-eat Cereal** **Bacon Curls** **Toast**	**Prune Juice** **Hot or Ready-to-eat Cereal** **Scrambled Eggs** **Toast**	**Grapefruit Juice** **Hot or Ready-to-eat Cereal** **Omelet** **Toast**	**Peach Juice** **Hot or Ready-to-eat Cereal** **3-Minute Egg** **Toast**	**Orange Juice** **Hot or Ready-to-eat Cereal** **Crisp Bacon** **Toast**
	P	Baked Rhubarb Hot or Ready-to-eat Cereal Fried Egg Toast	Sliced Oranges Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Bananas - Cream Hot or Ready-to-eat Cereal French Toast Preserves	Apple Sauce Hot or Ready-to-eat Cereal Link Sausage Orange Bowknots	Prune Juice Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Grapefruit Half Hot or Ready-to-eat Cereal Fried Egg Toast	Stewed Peaches Hot or Ready-to-eat Cereal Fruit Omelet Whole Wheat Toast	Orange Half Hot or Ready-to-eat Cereal Scrapple Pineapple Coffee Cake
LUNCH . .	H	Chilled Fruit Juice Chicken a la King in Toast Nests Potato Curls Spiced Fruit Salad Blueberry Tart	French Onion Soup Shrimp - Tomato-Egg Casserole Cottage Potatoes Krispy Relishes Cake Top Lemon Pie	Bouillon Cubed Steak Sandwich Julienne Potatoes Tossed Green Salad Raspberry Macaroon Float	Country Fried Chicken - Gravy Mashed Potatoes Cauliflower Polanaise Olives - Radish Roses Hot Fudge Ice Cr. Sun.	Alphabet Soup Escalloped Potatoes with Ham Banana Nut Salad Cherry Tapioca	Cream of Corn Soup Chili Con Carne With Crackers Combination Vegetable Salad Strawberry Shortcake	Consomme Ham Loaf Potato Cakes Tomato-Endive Salad Chocolate Filled Cookies	Creole Soup Vienna Roast Baked Potato Pineapple-Grated Cheese Salad Delicia Cake
	S	**Chilled Fruit Juice** **Creamed Chicken on Rusk** **Strawberry Ice Cream**	**Strained Soup** **Stuffed Deviled Eggs** **Baked Potato** **Cake Top Lemon Pudding**	**Bouillon** **Cubed Steak** **Riced Potatoes** **Butterscotch Blanc Mange**	**Strained Soup** **Roast Chicken** **Mashed Potatoes** **Bu. Peas** **Hot Fudge Ice Cream Sundae**	**Alphabet Soup** **Hot Roast Beef** **Escalloped Potatoes** **Cherry Tapioca**	**Strained Soup** **Cottage Cheese** **Beet Puree** **Maple Custard**	**Consomme** **Roast Turkey** **Riced Potatoes** **Chocolate Meringue Pudding**	**Strained Soup** **Beef Loaf** **Mashed Potatoes** **Vanilla Wafers**
	P	Chilled Fruit Juice Chicken a la King in Toast Nests Potato Curls Spiced Fruit Salad Blueberry Pie	French Onion Soup Shrimp - Tomato-Egg Casserole Cottage Potatoes Krispy Relishes Cake Top Lemon Pie	Bouillon Cubed Steak Sandwich Fr. Fr. Potatoes Tossed Green Salad Raspberry Macaroon Float	Country Fried Chicken - Gravy Mashed Potatoes Cauliflower Polanaise Olives - Radish Roses Hot Fudge Ice Cream Sundae	Alphabet Soup Baked Pork & Beans Boston Brown Bread Banana Nut Salad Cherry Tapioca	Cream of Corn Soup Chili Con Corne With Crackers Combination Vegetable Salad Strawberry Shortcake	Consomme Ham Loaf Potato Cakes Tomato-Endive Salad Chocolate Filled Cookies	Creole Soup Vienna Roast Baked Potato Pineapple-Grated Cheese Salad Delicia Cake
DINNER . .	H	Roast Fresh Ham Whipped Potatoes Frozen Peas Macedoine Salad Steamed Pudding - Lemon Sauce	Planked Salmon - Parsley Butter Bu. Crumb Potatoes Green Beans Cole Slaw Fruited Gelatin - Wh. Cr.	Lamb Pot Pie with Biscuits Bu. Noodles Wilted Spinach Salad Iced Apricot Tart	Two-Tone Cocktail Frizzled Beef Rarebit Potato Chips Frozen Fruit Salad Ice Box Cookies	Chicken Wings - Cream Gravy Spanish Rice Diced Carrots Lettuce Wedge - Fr. Dr. Washington Pie	Veal Cutlet Parmesan Paprika Potatoes Summer Squash Shredded Lettuce Royal Anne Cherries	Yankee Pot Roast Oven Browned Potatoes Cauliflower au Gratin Grape-Melon Ball Salad Peppermint Stick Ice Cream	Grilled Calves Liver Delmonico Potatoes Fresh Spinach Mounds Assorted Relishes Indian Pudding
	S	**Strained Soup** **Smothered Steak** **Whipped Potatoes** **Frozen Peas** **Bread Pudding - Lemon Sauce**	**Strained Soup** **Planked Salmon** **Bu. Crumb Potatoes** **Bean Puree** **Fruited Gelatin - Wh. Cr.**	**Strained Soup** **Broiled Lamb Pattie** **Bu. Noodles** **Baked Squash** **Peach Half**	**Two-Tone Cocktail** **Creamed Chipped Beef on Toast** **Baked Potato** **Sugar Wafers**	**Strained Soup** **Chicken Wings - Cream Gravy** **Fluffy Rice** **Diced Carrots** **Sunshine Cake**	**Strained Soup** **Veal Cutlet** **Bu. Potatoes** **Summer Squash** **Royal Anne Cherries**	**Strained Soup** **Yankee Pot Roast** **Baked Potato** **Bean Puree** **Vanilla Ice Cream**	**Strained Soup** **Broiled Calves Liver** **Delmonico Potatoes** **Spinach Puree** **Indian Pudding**
	P	Roast Fresh Ham Whipped Potatoes Frozen Peas Macedoine Salad Steamed Pudding - Lemon Sauce	Fried Oysters - Tartar Sauce Bu. Crumb Potatoes Green Beans Cole Slaw Fruited Gelatin - Wh. Cr.	Lamb Pot Pie with Biscuits Bu. Noodles Wilted Spinach Salad Iced Apricot Tart	Two-Tone Cocktail Frizzled Beef Rarebit Potato Chips Frozen Fruit Salad Ice Box Cookies	Grilled Ham Slice Escalloped Potatoes Diced Carrots Lettuce Wedge - Fr. Dr. Washington Pie	Breaded Veal Cutlet Paprika Potatoes Summer Squash Shredded Lettuce Royal Anne Cherries	Yankee Pot Roast Oven Brnd. Potatoes Cauliflower au Gratin Grape-Melon Ball Salad Peppermint Stick Ice Cream	Grilled Yearling Liver Delmonico Potatoes Fresh Spinach Mounds Assorted Relishes Indian Pudding

a broad spectrum dietary supplement

When anorexia interferes with the intake of needed foods in adequate amounts, the resultant effect on the nutritional status of the patient is considerably more apt to involve deficiency in several nutrients than in one particular nutrient. In consequence, unpredictable subclinical deficiency states may arise, which can seriously impede convalescence. Hence when anorexia is present, it is good prophylactic therapy to prescribe a dietary supplement of broad nutrient spectrum, capable of improving the intake of virtually all indispensable nutrients.

The dietary supplement Ovaltine in milk enjoys long-established usage in clinical practice. As is evident from the appended table, it supplies notable amounts of virtually all nutrients known to take part in metabolism. Its biologically complete protein provides an abundance of all the essential amino acids. It is delightfully palatable, easily digested, bland, and well tolerated.

Ovaltine is available in two varieties, plain and chocolate flavored, giving choice according to preference. Serving for serving, they are virtually alike in their wealth of nutrients.

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(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

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*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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St. Joseph's of St. Paul, Minn. to celebrate centennial in May

■ MINNESOTA'S OLDEST HOSPITAL, St. Joseph's of St. Paul, will observe its Centennial May 16 and 17, bringing world-famous medical personalities to the Northwest.

Among them will be Sir Alexander Fleming of London, England, discoverer of penicillin; Dr. Philip S. Hench of the Rochester Mayo Clinic, co-discoverer of cortisone, and Dr. Richard R. Trail of England, tuberculosis specialist. Both Sir Alexander Fleming and Dr. Hench are Nobel prize winners.

Other guests and speakers at the observance will include Dr. Louis H. Bauer of Hempstead, N.Y., president of the American Medical Association; Dr. Harold L. Foss of Danville, Pa., president of the American College of Surgeons; and Dr. William Boyd, pathologist of the University of Vancouver, B.C.

The two-day celebration will be devoted to sessions in either the Hotel Lowry or the Auditorium's theater section; a Centennial dinner in Hotel Lowry, and reunions of interns, staff physicians, and alumnae of the Department of Nursing.

A pontifical high mass will be celebrated on Sunday, May 17, in the Cathedral by Archbishop John Gregory Murray, emphasizing the religious significance of the hospital's history.

Founded in 1853 by the Sisters of St. Joseph, the hospital has added a number of historic "firsts" in its field.

The first successful complete removal of a gallbladder in America was done there in 1886 by Dr. Justus Ohage; in 1903 probably the nation's first formal bronchoscopy using a bronchoscope was performed by Dr. Arnold Schwyzer.

The hospital recently became the first in the area to take chest x-rays of all patients at the time they enter the hospital. ■

Favor full payment

■ HOSPITALS should be compensated in full by third party agencies, agreed speakers at the Feb. 27 meeting of the Greater New York Hospital Association. ■

H = house (normal or general) diets

monthly menus hm ... April 1953

H = house (normal or general) diets
S = soft diets
P = personnel menus

		Fri. April 17	Sat. April 18	Sun. April 19	Mon. April 20	Tues. April 21	Wed. April 22	Thurs. April 23	Fri. April 24
BREAKFAST . .	H	Baked Apple Hot or Ready-to-eat Cereal Baked Egg Toast	Tangerine Juice Hot or Ready-to-eat Cereal Scrambled Eggs Raisin Toast	Frozen Strawberries Hot or Ready-to-eat Cereal Crisp Bacon Brioche	Grapefruit Half Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Sliced Bananas—Cream Hot or Ready-to-eat Cereal Poached Egg Toast	Sliced Oranges Hot or Ready-to-eat Cereal Omelet Toast	Pineapple Wedges Hot or Ready-to-eat Cereal Scrapple Pecan Coffee Cake	Cinnamon Prunes Hot or Ready-to-eat Cereal Scrambled Eggs Toast
	S	Apple Juice Hot or Ready-to-eat Cereal Baked Egg Toast	Tangerine Juice Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Cherry Nectar Hot or Ready-to-eat Cereal Crisp Bacon Toast	Grapefruit Juice Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Sliced Bananas-Cr. Hot or Ready-to-eat Cereal Poached Egg Toast	Orange Juice Hot or Ready-to-eat Cereal Omelet Toast	Pineapple Juice Hot or Ready-to-eat Cereal Bacon Curls Toast	Grape Nectar Hot or Ready-to-eat Cereal Scrambled Eggs Toast
	P	Baked Apple Hot or Ready-to-eat Cereal Shirred Egg Toast	Tangerine Juice Hot or Ready-to-eat Cereal Scrambled Eggs Raisin Toast	Frozen Strawberries Hot or Ready-to-eat Cereal Crisp Bacon Brioche	Grapefruit Half Hot or Ready-to-eat Cereal 3-minute Egg Toast	Sliced Banans—Cream Hot or Ready-to-eat Cereal Fruit Griddle Cakes Syrup	Sliced Oranges Hot or Ready-to-eat Cereal Fried Egg Toast	Pineapple Wedges Hot or Ready-to-eat Cereal Scrapple Pecan Coffee Cake	Cinnamon Prunes Hot or Ready-to-eat Cereal Scrambled Eggs Toast
LUNCH . .	H	Dixie Chowder Cold Fresh Salmon with Peas Potato Puff Pickled Beet Salad Iced Gingerbread	Vegetable Soup Braised Pork Chop Chantilly Potatoes Cinnamon Apple Ring Salad Date Bars	Blended Fruit Juice Sirloin Tips—Bordelaise Sauce Shoestring Potatoes Bu. Carrots & Peas Grapefruit—Avocado Salad Oriental Ice Cr. Sun.	Carrot-Celery Soup Hot Roast Beef Sandwich Latticed Potatoes Indian Relish Salad Blackberry Cobbler	Potato Chowder Crisp Bacon Blackeyed Peas Cornbread Muffin—Jelly Red Cabbage Salad Apple Sauce	Scotch Broth Corn Beef Pattie Hot Slaw Garden Salad Rhubarb Cream Tart	Noodle Soup Pressed Chicken Bu. Asparagus on Toast Endive-Tomato Salad Chocolate Mint Ice Cream	Hot Tomato Juice Tuna-Egg, Creole Lyonnaise Potatoes Lettuce Wedge-Herb Dr. Ambrosia-Custard Sauce
	S	Strained Soup Baked Salmon with Peas Potato Puff Peach Custard	Strained Soup Roast Lamb—Gravy Chantilly Potatoes Gelatine Cubes—Wh. Cr.	Blended Fruit Juice Braised Sirloin Tips Mashed Potatoes Bu. Carrots & Peas Banana Ice Cream	Strained Soup Roast Beef—Gravy Baked Potato Caramel Pudding	Strained Soup Crisp Bacon Duchess Potatoes Apple Sauce	Scotch Broth Broiled Beef Pattie Riced Potatoes Four Fruit Pudding	Noodle Soup Pressed Chicken Creamed Peas Chocolate Ice Cream	Hot Tomato Juice Tuna-Egg Casserole Stuffed Baked Potato Lemon Milk Sherbet
	P	Dixie Chowder Cold Fresh Salmon with Peas Potato Puff Pickled Beet Salad Iced Gingerbread	Vegetable Soup Braised Pork Chop Chantilly Potatoes Cinnamon Apple Ring Salad Date Bars	Blended Fruit Juice Minute Steak Shoestring Potatoes Bu. Carrots & Peas Grapefruit—Avocado Salad Oriental Ice Cr. Sun.	Carrot-Celery Soup Wieners—Buns Latticed Potatoes Indian Relish Salad Blackberry Cobbler	Potato Chowder Crisp Bacon Blackeyed Peas Cornbread Muffins—Jelly Red Cabbage Salad Apple Sauce	Scotch Broth Corn Beef Hash Hot Slaw Garden Salad Rhubarb Cream Pie	Noodle Soup Pressed Chicken Bu. Asparagus on Toast Endive-Tomato Salad Chocolate Mint Ice Cream	Hot Tomato Juice Tuna-Egg, Creole Lyonnaise Potatoes Lettuce Wedge-Herb Dr. Ambrosia-Custard Sauce
DINNER . .	H	Barracuda Steak Watercress Potatoes Breaded Tomatoes Green Salad Frosted Fruit Cocktail	Carolina Meat Pie Succotash Asparagus—Egg Salad Cherry-Pineapple Upside Down Cake	Mushroom Bisque Chicken Salad on Toasted Roll Stuffed Celery Salad Refrigerator Cheese Cake	Breaded Lamb Steak New Potatoes in Jackets Pimiento Wax Beans Fiesta Salad Cottage Pudding—Fruit Sauce	Boiled Beef—Horseradish Sauce Escalloped Potatoes Braised Celery Bing Cherry Salad Graham Cracker Roll	Stuffed Flank Steak Creamy Rice Hot Spiced Beets Marinated Cucumbers Sour Cr. Butterscotch Pear	Veal Birds Whipped Potatoes Frozen Peas Cherry-Nut Salad Sunshine Cake	Baked Shad Maitre d'Hotel Potatoes Spinach Mounds Krisped Relishes Raisin-Rice Pudding
	S	Strained Soup Baked Halibut Bu. Potatoes Julienne Carrots Frosted Fruit Cocktail	Strained Soup Broiled Veal Chop Creamed Potatoes Bu. Asparagus Tips Floating Island	Strained Soup Chicken-Rice Casserole Refrigerator Cheese Cake	Strained Soup Fillet of Lamb Bu. Potatoes Bean Puree Canned Apricots	Strained Soup Boiled Beef Escalloped Potatoes Bu. Peas Graham Cracker Roll	Strained Soup Stuffed Flank Steak Creamy Rice Beet Puree Butterscotch Pear	Strained Soup Veal Cutlet Whipped Potatoes Bu. Asparagus Tips Sunshine Cake	Strained Soup Baked Whitefish Bu. Potatoes Spinach Puree Raisin-Rice Pudding
	P	Barracuda Steak Watercress Potatoes Breaded Tomatoes Green Salad Frosted Fruit Cocktail	Carolina Meat Pie Succotash Asparagus—Egg Salad Cherry-Pineapple Upside-Down Cake	Mushroom Bisque Chicken Salad on Toasted Roll Stuffed Celery Salad Refrigerator Cheese Cake	Breaded Lamb Steak New Potatoes in Jackets Pimiento Wax Beans Fiesta Salad Cottage Pudding Fruit Sauce	Boiled Beef—Horseradish Sauce Escalloped Potatoes Braised Celery Bing Cherry Salad Graham Cracker Roll	Flank Steak Roll Creamy Rice Hot Spiced Beets Marinated Cucumbers Sour Cr. Butterscotch Pear	Veal Birds Whipped Potatoes Frozen Peas Cherry-Nut Salad Sunshine Cake	Codfish Balls Maitre d'Hotel Potatoes Spinach Mounds Krisped Relishes Raisin-Rice Pudding

monthly menus hm ... April 1953

H = house (normal or general) diets
S = soft diets
P = personnel menus

		Sat. April 25	Sun. April 26	Mon. April 27	Tues. April 28	Wed. April 29	Thurs. April 30
BREAKFAST . .	H	Kadota Figs Hot or Ready-to-eat Cereal 3-Minute Egg Toast	Grapefruit Half Hot or Ready-to-eat Cereal Link Sausage Graham Muffins-Jelly	Pineapple Juice Hot or Ready-to-eat Cereal Baked Egg Toast	Orange Segments Hot or Ready-to-eat Cereal Scrambled Eggs Toast	Apple Sauce Hot or Ready-to-eat Cereal Bacon Curls Kolaci	Tomato Juice Hot or Ready-to-eat Cereal 3-Minute Egg Toast
	S	**Blended Fruit Juice** **Hot or Ready-to-eat Cereal** **3-Minute Egg** **Toast**	**Grapefruit Juice** **Hot or Ready-to-eat Cereal** **Crisp Bacon** **Toast-Jelly**	**Pineapple Juice** **Hot or Ready-to-eat Cereal** **Baked Egg** **Toast**	**Orange Juice** **Hot or Ready-to-eat Cereal** **Scrambled Eggs** **Toast**	**Apple Sauce** **Hot or Ready-to-eat Cereal** **Bacon Curls** **Toast**	**Tomato Juice** **Hot or Ready-to-eat Cereal** **3-Minute Egg** **Toast**
	P	Kadota Figs Hot or Ready-to-eat Cereal 3-Minute Egg Cinnamon Toast	Grapefruit Half Hot or Ready-to-eat Cereal Link Sausage Graham Muffins-Jelly	Pineapple Juice Hot or Ready-to-eat Cereal French Toast Preserves	Orange Segments Hot or Ready-to-eat Cereal Fried Egg Toast	Apple Sauce Hot or Ready-to-eat Cereal Bacon Curls Toast	Tomato Juice Hot or Ready-to-eat Cereal French Omelet Toast
LUNCH . .	H	Julienne Soup Spaghetti Italienne With Tiny Meat Balls Cabbage-Pineapple Salad Toasted French Bread Green Gage Plums	Chilled Fruit Juice Br. Chicken-Mushr'ms Mashed Potatoes Asparagus Tips Vinaigrette Sauce Perfection Salad Neapolitan Ice Cream	Vegetable Soup Broiled Lamb Pattie Delmonico Potatoes Mexican Salad Strawberries-Cream Wafers	Consomme Canadian Bacon Potato Cakes Tomato-Lettuce Salad Mincemeat Cookies	Cream of Asparagus Soup Frizzled Beef with Hot Biscuits Adirondack Salad Coconut Cake Squares	Bouillon Turkey a la King in Mashed Potato Nest Spring Carrots Shredded Lettuce Strawberry Ice Cream
	S	**Julienne Soup** **Broiled Beef Pattie** **Spaghetti With Strained Tomatoes** **Toasted French Bread** **Royal Anne Cherries**	**Chilled Fruit Juice** **Broiled Chicken** **Mashed Potatoes** **Bu. Asparagus Tips** **Neapolitan Ice Cream**	**Strained Soup** **Broiled Lamb Pattie** **Delmonico Potatoes** **Fruit Whip** **Wafers**	**Consomme** **Beef-Noodle Casserole** **Snow Pudding**	**Cream of Asparagus Soup** **Beef Loaf** **Baked Potato** **Pear Gelatine-Wh. Cr.**	**Bouillon** **Creamed Turkey in Mashed Potato Nest** **Spring Carrots** **Strawberry Ice Cream**
	P	Julienne Soup Spaghetti Italienne With Tiny Meat Balls Cabbage-Pineapple Salad Toasted French Bread Green Gage Plums	Chilled Fruit Juice Fr. Chicken-Crm Gravy Mashed Potatoes Asparagus Tips Vinaigrette Sauce Perfection Salad Neapolitan Ice Cream	Vegetable Soup Broiled Lamb Pattie Delmonico Potatoes Mexican Salad Cabinet Pudding	Consomme Cold Luncheon Meats Corn Fritters-Syrup Tomato-Lettuce Salad Mincemeat Cookies	Cream of Asparagus Soup Frizzled Beef With Hot Biscuits Adriondack Salad Coconut Cake Squares	Bouillon Turkey a la King in Mashed Potato Nest Spring Carrots Shredded Lettuce Strawberry Ice Cream
DINNER . .	H	Crown Roast of Lamb Parslied New Potatoes Julienne Carrots Beet Slaw Banana Custard Cake	Mulligatawny Soup Toasted Ham & Cheese Sandwich Potato Chips Fruit Salad Chocolate Fudge Pudding	Roast Loin of Pork Sauted Sweet Potatoes Green Beans, Gascon Spring Salad Apple-Raisin Cobbler	Smothered Steak Watercress Potatoes Bu. Zucchini Leaf Lettuce-Sour Cr. Dr. Rhubarb Brown Betty	Stuffed Roast Shoulder of Veal Lima Beans Grated Beets Lettuce Toss Fresh Pineapple Wedges	Grilled Ham Steak New Potatoes in Jackets Spinach a la Swiss Relish-Celery Salad Fruited Cream Puff
	S	**Strained Soup** **Crown Roast of Lamb** **Bu. Potatoes** **Diced Carrots** **Banana Custard Cake**	**Mulligatawny Soup** **Cottage Cheese** **Bu. Peas** **Spanish Cream**	**Strained Soup** **Roast Beef-Gravy** **Potato Puff** **Bean Puree** **Escalloped Apples**	**Strained Soup** **Smothered Steak** **Bu. Potatoes** **Summer Squash** **Peach Melba**	**Strained Soup** **Stuffed Roast Shoulder of Veal** **Riced Potatoes** **Beet Puree** **Fros. Graham Crackers**	**Strained Soup** **Broiled Lamb Chop** **Bu. Patotoes** **Spinach Puree** **Chocolate Sponge**
	P	Crown Roast of Lamb Parslied New Potatoes Julienne Carrots Beet Slaw Banana Custard Pie	Mulligatawny Soup Toasted Ham & Cheese Sandwich Potato Chips Fruit Salad Chocolate Fudge Pudding	Roast Loin of Pork Sauted Sweet Potatoes Green Beans, Gascon Spring Salad Apple-Raisin Cobbler	Smothered Steak Watercress Potatoes Bu. Zucchini Leaf Lettuce-Sour Cr. Dr. Rhubarb Brown Betty	Stuffed Roast Shoulder of Veal Lima Beans Grated Beets Lettuce Toss Fresh Pineapple Wedges	Grilled Ham Steak New Potatoes in Jackets Spinach a la Swiss Relish-Celery Salad Fruited Cream Puff

✦

Friday, April 3
is
Good Friday

✦

Sunday, April 5
is
Easter

✦

continued from page 88

Trained dietitians have rendered, and are still rendering real professional service, else the scope of their work and the demand for them would not have grown as it has. Some of us have been criticized for lack of ability to organize and administer the departments for which we are responsible. There are misfits in every field. There are also degrees of competence among the individuals in every profession or occupation. Let us not censure inexperience, but only lack of capacity for growth.

Administrative ability is *developed,* and regardless of background training most of that development must come on the job.

Since 1946 I have followed rather closely the careers of numerous young dietitians. Certainly their ability varies, each having some strengths, some weaknesses. Many of them, because of the great need for dietitians, have tackled jobs that were too big for a beginner, but almost without exception when they have been fortunate enough to come under the direction of an administrator interested in development of his staff, they have succeeded in making an adequate contribution to the work of the hospital with which they have allied themselves.

Perhaps that dietitian on your staff who is doing a mediocre job needs only the inspiration which would come from being approached as part of the professional team, to make her try harder and grow in ability! Be honest with her, but be fair. Share your dreams for improvement of the hospital with her . . . she may have some too that she has been afraid to tell you about.

If you have a dietitian who is doing a good job tell her so occasionally. Timely praise will make her better able to face the criticism which is sure to be necessary sooner or later.

I think that the administrator has a responsibility to see that his dietitian is encouraged to participate in professional activities. It would be interesting to know how many hospitals are represented here today by both the administrator and his dietitian.

And now, I want to say a few things to the dietitians. Perhaps some of this is what your administrator would like to say to you and lacks the courage:

1. Grow up! Mature thinking is one of the greatest needs of our generation. When we cease being self-centered and start thinking about the greatest good for the greatest number we will *deserve* our professional status. Make the goals of the hospital in the care of the sick, your goals. There is no greater happiness in life than that which comes from alliance with a cause greater than yourself and giving it everything you have.

2. Be more selective about the position you accept, but plan to stay with it more than one year. The only really good excuse for leaving a job after twelve months is marriage and a family. On a new job

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Even a general or "special diet" kitchen may be obsolete or antiquated and may need modernizing. Dish washers, food mixers, apple parers, potato peelers, food carts and other equipment will save time. These and others of the 50,000 items you may need are sold by DON. Every item sold on a guarantee of satisfaction or money back.

Write Dept. 21 for a DON salesman to call — or in Chicago phone CAlumet 5-1300.

EDWARD DON & COMPANY
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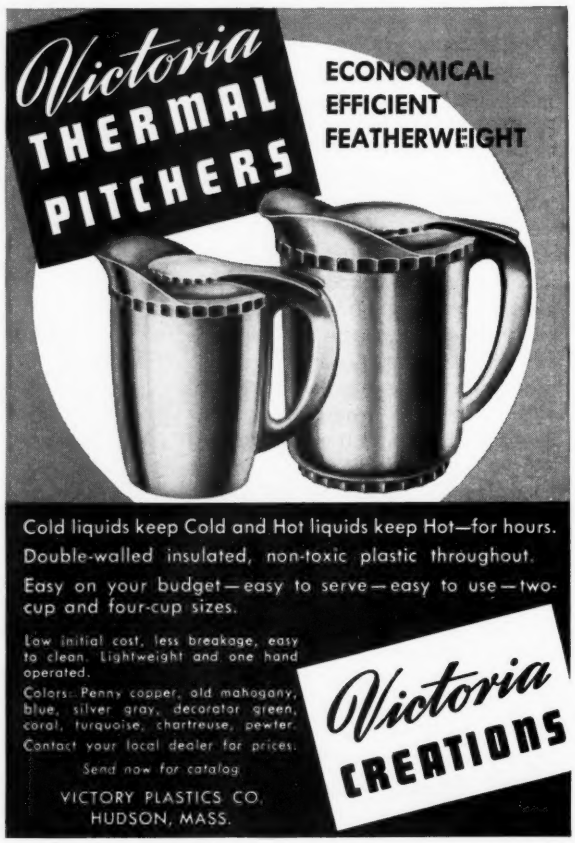

Cold liquids keep Cold and Hot liquids keep Hot—for hours.
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it takes a year to start to grow.

3. Strive for technical competence, but *above all,* strive for emotional maturity. Some of us live to be 80 and never achieve it, but *more than any other quality* it will mean success or failure.

Some of you administrators, I know, are saying, "That is all very fine for those who have a dietitian, but what about those of us who have vacancies we have been unable to fill, or whose hospitals are too small to support a professional person in charge of food service?" I believe that there is a solution for the small hospital.

When groups of two or three small hospitals geographically situated within reasonable driving distance can band together and mediate their differences enough to share the financial responsibility, they will be able to find capable dietitians who will organize their food services, train non-professional resident help to do an adequate job, and at the same time render the type of professional nutritional service good physicians expect. Many of our American Dietetic Association members are doing this type of work, but the initiative must come from the hospitals, they must have a definite plan and agreement before a good dietitian will consider such a situation.

Part of the remedy for the shortage of dietitians in the hospital field must come from the hospitals themselves. I am concerned about the numbers of dietitians who are being welcomed into the commercial field and finding job satisfactions sometimes denied them in hospital service.

No longer are our hospital trained dietitians assured recruits for the field of hospital dietetics. They have a wide choice in industrial feeding, community nutrition services, school lunch, college food service, catering, research and experimental kitchens, *and* hospital dietetics.

Can the place that you offer a dietitian in your hospital compete? It can if you offer her (a) a place on the professional team, (b) an opportunity to grow, (c) the stimulus of working with others toward a common goal. ■

Traffic Control

continued from page 43

Part of a $200,000 three-story addition to an existing hospital, the emergency area is, of course, on the first floor, with direct access to the ambulance entrance. Litters may be wheeled in to the central section of the suite, as shown in the sketch, (Fig. 5) and patients taken directly into the X-ray room. After the extent of bone fracture is determined, they can be wheeled into the emergency operating room, which will also double for orthopedic surgery. Right off the operating room is the splint room. At far left in the sketch can be seen the Cassette Pass into the X-ray darkroom; at far right, on the wall of the operating room, are the X-ray film viewers.

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.....And here's a selection of "76" Menu Products of particular interest to Hospital Dietitians

CREAM DESSERTS, with sugar and milk, Lemon, Chocolate, Butterscotch, Vanilla, Tapioca and Asst'd.
GELATIN DESSERTS, Orange, Lemon, Lime, Strawberry, Raspberry, Cherry Asst'd and Asst'd Red. Plain Unsweetened.
TEAS
SOUP MIXES
W-B Chicken Soup Mix
W-B Noodle Soup Mix
W-B Beef Soup Stock
W-B Onion Soup Mix
PURE EGG NOODLES
MACARONI-SPAGHETTI
PANCAKE MIX
WAFFLE-PANCAKE SYRUP
HOT CHOCOLATE
CHOCOLATE SYRUP
HOT FUDGE
SPICES
CHILI CON CARNE
EXTRACTS
COLORINGS
SALAD DRESSINGS
MAYONNAISE
FRENCH DRESSING
THOUSAND ISLAND DRESSING
MALTED MILK, plain

Constance Conover, our Director of Quantity Recipes, has developed many new recipes for delicious, low-cost dishes. Ask your Continental man for free copies of the latest assortment.

MAKERS OF CONTINENTAL'S FAMOUS "76" MENU PRODUCTS

New system for supplies accounting gains popularity

by G. J. Bartel Administrator, St. Mary's Hospital • Montreal, P. Que., Canada

■ A GREAT SOURCE of irritation to the hospital administrator . . and especially to the accounting department . . is the control and accounting of supplies used in the daily services to patients. Some would like this accountable every day; others choose a monthly, quarterly or yearly basis.

The problem has had much discussion because the fact remains that while the supplies are necessary for good care, accounting for control is necessary so that policies can be determined and true total costs ascertained. On the other hand, spending money to accumulate this information seems almost folly, for when it is obtained what can be done about it? Cost of supplies can be from $2 to $8 per patient day depending on the type of service given. And while individual personnel can be requested verbally to be careful about usage, where actually can the line be drawn, since the welfare of the patient is at stake?

Three methods . . for the accounting of used supplies are in general use. Two, the results of short cuts, are hampered by certain basic inaccuracies but nevertheless give enough information to use on the monthly statement and to afford some basis of control. These three are as follows:

■ **1.** Using the cost of the monthly supplies purchased during the month as the amount stipulated as used during that month.

This method . . of charging the supplies purchased during the month as the cost . . can be truly erroneous. In the long run, of course, it will average somewhere near what is actually used. When, however, a large supply is laid away for three or four months, to take advantage of quantity purchases, it is all wrong to charge it into the one 30-day period. The weakness of this system is evident. Besides showing a distorted picture of usage, it affords no control or accountability of departmental use. Merely a way to escape more onerous but more precise procedures, it is nonetheless still used by a good percentage of hospitals.

■ **2.** Stores requisitions systems.

Stores requisitions have been criticized because of the paper work involved. It requires clerks to enter the cost of the materials and add up such totals as will give a semblance of an accurate figure. This system has long been used in places where the matter of costs of operation is a secondary consideration, for it is combined with a perpetual inventory system.

■ **3.** Projecting into the present year the average cost per patient day of supplies during the past year, with an inventory adjustment account of approximately 3 per cent on the total for final calculations.

This method is relatively new in the thinking of hospital accounting. It is an outgrowth of not wanting to use the first or second methods because of the reasons set forth above. After the average cost per patient day for supplies during the previous year has been determined, the current month is charged at the same rate. It is found by multiplying the number of patient days by the average cost per day for supplies purchased in the preceding year. As noted, there must be an inventory adjustment account in order to take care of (a) any increase or decrease in prices or (b) increased or decreased usage of supplies. No final figure can be given until the inventory is taken at the end of the year. Advocates of this system point out that it is simple to ascertain, economical to keep and gives a reasonable degree of accuracy. They also point out that it can be departmentalized, if necessary.

A fourth method . . should be considered as it is gaining popularity because of its accuracy and its economical factors. It gives all the data necessary besides having the advantage of a human relations factor with regard to the personnel of the hospital. This system can be called a *priced stores catalogue.*

The catalogue itself is merely a tool of information for those who are using and ordering supplies. The first reaction of individuals usually is that it serves to suggest additional methods of supply usage which would not otherwise occur to personnel. This "danger" is not present in other systems but we can discount this because it can be a source of information for the better care of the patient.

It combines the popular catalogue system with that of basic account-

ing. In the stores catalogue the prices are arranged at what is anticipated to be the cost for the year. Under present conditions this is possible because of anticipated stabilization of prices but the adjustment account must be kept open for any unusual rise in price in certain supplies, the rising demand on a certain article or the induction of new supplies. However, the adjustment account will not need to be as high as 3 per cent of the total inventory anticipated, used in the average cost per day, but will need to be approximately 1 per cent.

The stores catalogue is divided into several parts, namely Medical and Surgical, Housekeeping Supplies, Stationery, Printing, etc. These will cover most of the usage within the hospital. Each catalogue is printed with plenty of blank numbers for introduction of new types of supplies. Such supplies to special departments as laboratory, x-ray, dietary, are individually listed. The same method of ordering is used throughout. The store room has a complete catalogue available of all supplies of all adjunct services as well as those basic ones. A code number representing each type of supply is used, in addition to a stock number. The code number precedes the stock number (e.g., for medical and surgical supplies the code number may be "1" as illustrated . . razor blades are stock number 65. Thus their code-stock number is 1-65. In stationery supplies, the code is "3," and pencil erasers are stock number 34. Their full code is therefore 3-34).

By formulating a requisition slip, which we shall call Purs. 8 (see cut of form at right), the individual ordering stock can furnish all information necessary to obtain the supplies. This form has several designated columns: 1. the far left-hand side contains the stock number; 2. the next two columns are for the quantity and the unit form of supplies; 3. the fourth column or center is for the description of the material as the catalogue lists it; 4. the fifth and sixth columns are for the storekeeper (entitled "quantity delivered and the unit," which has the same reference as columns 3 and 4). 5. The seventh column "unit price" for an individual item, and 6.

Committee on Accounting & Statistics . . of the Massachusetts Hospital Association

Novel clinic technique solves accounting problems

■ HOSPITAL ACCOUNTING PERSONNEL were brought face to face with the experts in the Massachusetts Hospital Association annual meeting on January 20, 1953. Personal consultation on hospital fiscal problems was provided in a novel use of the diagnostic clinic technique associated generally with hospital outpatient departments. Members of the MHA Council on Administrative Practice and its sub-committee on Accounting and Statistics occupied key positions on the problem clinic staff.

Shown in the photo above are, seated left to right: Elmer C. Gould, E. Priscilla Bailey, John E. Pierce and Edward S. Lancaster. Standing are: Austin S. Curtis (left), and George S. Watts. ■

SAMPLE ORDER

St. Mary's Hospital

STORES REQUISITION

A separate line must be used for each different item or size. Group items as follows: Clinical supplies, cleaning supplies, and linen, printing and office supplies.

DEPARTMENT OR FLOOR 3rd Floor (South) DATE May 15,1952

ORDERED BY C. Smith

STOCK NUMBER	QUANTITY	UNIT	DESCRIPTION	QUANTITY DELIVERED	UNIT	UNIT PRICE	EXTENSION	ACCT. NO.
1- 5	2	boxes	Adhesive plaster, surgical			3.75	$ 7.50	
1-76	6	only	Catheters #8, plain			5.30doz.	2.68	
1-119	24	each	Connecting tubes, 3/8" glass			.05	1.20	
2- 4	6	each	Batteries #935			.12	.72	
2-22	1	M	Cups, paper #500			5.33	5.33	
2-28	2	rolls	Towels rolls			.26	.52	
3-55	2	M	Paper #40- 8½ x 5½			1.35	2.70	
3-71	3	rolls	Adding Machine			.13	.39	
4-35	4	pads	Graphic Sheets			.15	.60	
4-64	5	pads	Progress Notes			.15	.75	
						TOTAL	$22.39	

Requested by T. Holmes Dept. Head.

Approved G.J. Bartel, Administrator

Reorder on next requisition items marked B/O.

Purs. 8

the "extension" or eighth column, is to account for the amount spent on one item. The last column "account number" is reserved for the accounting department.

Since ordering must be done by some one person (perhaps the ward secretary with a few extra minutes), the complete charges to the department are accumulated at that time. After all of the necessary supplies have been ordered, the extension column is totalled and the individual department immediately knows how much has been spent or used for supplies in one week.

It is recommended that only one weekly order be accepted. In this way not only is it possible to account to the individuals immediately but it also is a simple way of doing the accounting. Secondly, it has a tremendous psychological effect upon the individuals in the departments to be able to note the cost of supplies.

An original and one copy are submitted to the store room with the second copy kept on the floor. The storekeeper fills the order according to the code-stock number and description (using mostly the code-stock number) which is attached to all supplies available. After the order is filled, the copy is returned with the supplies to the department. The returned copy indicates any changes necessary and indicates the degree of completion of the order.

With this system, it may be observed that

1. The department is doing its own accounting.
2. The total usage can be given to it by merely adding the four orders of the month.

   If segregation into different categories is necessary for each department, an adding machine tape combining all the code numbers will give the details, e.g., by adding all No. 1 (Medical and Surgical) for the four orders, the department can be informed of its usage for the month in this category. By merely adding up all the No. 1 (Medical and Surgical) in all orders, the total usage in the hospital for the month can be obtained.

A few minutes of work by the order originator can save a great amount of time and aids the accounting department in its tedious task of obtaining details. It must be admitted that it does have some shortcomings:

1. Because people have to be trained for proper completion of this order.
2. Because the stock supply must be carefully watched as unfulfilled orders will tend to defeat the economical factor.
3. The catalogue must be corrected for price yearly or addendums must be sent out showing new prices or when new types of supplies are added.
4. Material costs do change so the inventory adjustment account may not be able to care for what it is so intended.

There may be others, but just as any system has its shortcomings weighed against what thus far has been offered, this will justify its adoption.

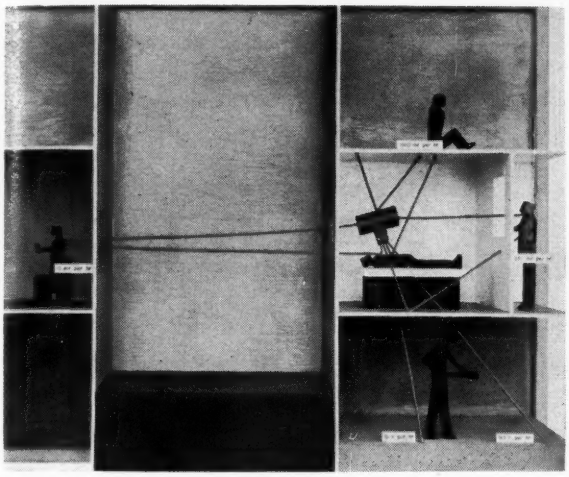
At the end of the year the regular procedure is followed. The inventory account from the previous year is added to the amounts purchased and from this is subtracted the new inventory; that figure is the amount of supplies taken from the store room. The total of all stores requisitions should equal this amount. The inventory adjustment account will generally take care of discrepancies with the allowance of 1 per cent for the total. ■

Sample Supplies Catalog Used by the Author

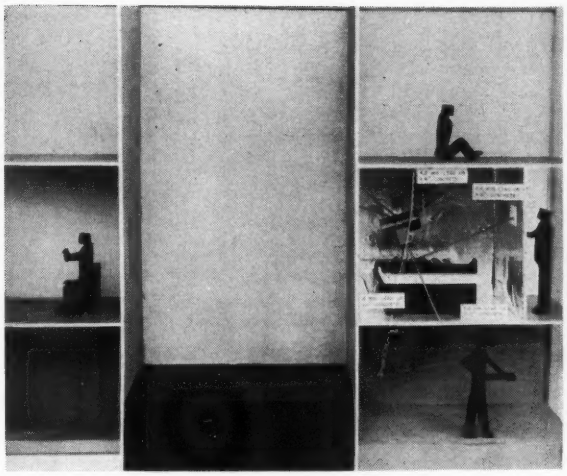
CLASS 1
Medical and Surgical Supplies

Stock No.	Description	Price	Per
1 - 1	Absorbent Cotton "Middlesex"	2.13	5 lb. roll
1 - 2	Absorbent Cotton "Lees"	1.09	1 lb. roll
1 - 3	Absorbent Cotton "Raritan"	1.00	1 lb. roll
1 - 4	*		
1 - 5	Adhesive Plaster, Surgical, cut ½" (and 5 other numbers, with 1 blank)**	3.75	box
1 - 11	Adhesive Plaster, Moleskin, 7" x 1 yd.	9.72	roll
1 - 12			
1 - 13	Applicators, cotton tipped 3", wood (and 2 other numbers, 1 blank)	3.35	box of 2M
1 - 16	Bandage, Adhesive, (Band-Aid) ¾"	0.83	box
1 - 17	Bandage, Cellucotton	2.36	5 lb. roll
1 - 18			
1 - 19	Bandage, Elastoplast, 2½" (and 3 other numbers, 1 blank)	0.72	roll
1 - 23	Bandage, Elastoplast strips 1½" x 1 yd	0.45	box
1 - 24	Bandage, Elastoplast strips 2½" x 1 yd	0.55	box
1 - 25	Bandage, Elastocrepe, 2½" (and 3 other numbers, 1 blank)	0.56	roll
1 - 29	Bandage, Gypsona, 3" (Fast Settings) (and 3 other numbers, 1 blank)	3.15	12-roll box
1 - 29	Bandage, Ichthopaste	7.00	12-roll box
1 - 30	Bandage, Ichthopaste		
1 - 31	Bandage, Jelonet (36 pcs. to box)	1.05	box
1 - 32			
1 - 33	Bandage, Orthoplast, 2" (and 3 other numbers)	1.60	12-roll box
1 - 37	Bandage, Rolls "New Wrap" cut 1" (and 3 other numbers)	7.50	box
1 - 41	Bandage, Stockinet, Surgical 2" (25-yd roll) (and 4 other numbers)	0.11	yard
1 - 46	Bandage, Surgi-tube, 1" (and 5 other numbers, 4 blank)	4.50	roll
1 - 52	Basins, Medium, Stainless Steel (and 2 other numbers)	5.45	each
1 - 55	Baxter Sets — R 11	0.55	each
1 - 56	Bed Pan, Adult, Stainless Steel	14.25	each
1 - 57	Bio-Sorb Dusting Pwder Pkts — B-208	3.60	box
1 - 58	Blades, Bard Parker (Surgical) #10 (and 6 other numbers, 1 blank)	14.40	gross
1 - 65	Blades, razor, safety	0.10	pkg.
1 - 66	Bottle, McKesson style	1.70	each
1 - 67	Bottle, combine, Ice & Water, stopperless	2.10	each
1 - 68			
1 - 69	Bowls, Sponges, Stainless Steel	2.45	each
1 - 70	Boxes, round, white (sputum)	0.04	each
1 - 71	Breast Pump	0.25	each
1 - 72	Brushes, scrub, hand (surgical)	5.25	doz.
1 - 72	Brushes, tooth, children's size (and 2 other numbers, 1 blank)	0.10	each
1 - 75	Cans, Irrigating with tips, White Enam.	1.42	each
1 - 76	Catheter, No. 8, plain (and 24 other numbers, 3 blank)	5.35	doz.
1 - 101	Cement, Liquisilk	0.35	tube
1 - 102	Cement, Patching, for rubber gloves	0.15	tube
1 - 103	Celluwipes, 5" x 9" (Kleenex)	0.07	box
1 - 104	Clips, Wound "Justrice" (and 4 other numbers, 1 blank)	5.04	box — 1M
1 - 109	Collar, Ice Bag, for throat	1.75	each
1 - 110	Cork, rubber	1.10	doz.
1 - 111	Corks, for Baxter sets	0.35	each
1 - 112	Combs, fine	0.15	each
1 - 113	Combs, dressing	0.35	each
1 - 114	Cotton Balls — Medium — 2,000	4.50	box
1 - 115	Cotton Balls — Small — 4,000	5.50	box
1 - 116	Connecting tubes — glass — ⅜ x 2¾ (and 4 other numbers)	1.20	doz.
1 - 121	Connectors, glass Y, small (and 4 other numbers)	2.00	doz.

* This is an "open" number, to which no item is yet assigned.
** When the title of an item is repeated more than once, this repetition has been omitted here to save space and a notation made as to how many numbers have been assigned it, together with blank numbers.



Wrong Model shows inadequate shielding of personnel, permitting x-ray radiation to reach adjoining areas



Right Model above shows adequate shielding of operator in the control booth, and persons in adjacent rooms

New light on x-ray protection design

This summary of a technical report released by the National Bureau of Standards provides latest authoritative data on a vital topic

■ ACCOMPANYING THE INCREASED APPLICATION of x-ray equipment and techniques is the growing need for specially designed treatment rooms. One of the major problems involved in any building program of this type is that of protecting the persons working with the equipment and those in adjoining areas. Many publications are available to assist in the solution of this problem, but none has undertaken to explain certain assumptions and recommendations nor has any included detailed design specifications. Extensive computations and analyses by the National Bureau of Standards of all phases of the problem have resulted in the development of detailed procedures for the design of barriers for x-ray protection.

The results of the NBS program . . including x-ray protection recommendations, sample design problems, and methods for computing barrier thickness . . are presented in a handbook which should prove valuable to administrators and x-ray department heads, as well as to architects and engineers planning structures in which x-ray equipment is to be used.[1] The primary factual data and basic principles necessary for designing shielded x-ray installations included in the publication are based on the recommendations of the National Committee on Radiation Protection.[2]

X-ray protective barriers . . can be divided into two types: a primary barrier, providing protection against the useful radiation or beam; and a secondary barrier, providing protection against the secondary and direct radiation. Thus, if an x-ray tube is fixed in position, the portion of the wall or floor struck by the radiations passing through the tube-housing aperture, cone, or diaphragm (the useful beam) will require a primary protective barrier.

Secondary protective barriers will be required for all other areas receiving the radiations escaping through the tube housing (direct radiation) and the radiations originating in the irradiated material (secondary radiations). If the tube may be aimed in every direction, all walls must be considered as subject to useful radiations and therefore

Target distance	Lead thickness with peak of—				
	75 kv	100 kv	150 kv	200 kv	250 kv
ft	*mm*	*mm*	*mm*	*mm*	*mm*
2	2.2	3.4	4.3	6.7	11.8
3	2.0	3.1	4.0	6.2	10.9
5	1.7	2.7	3.6	5.5	9.6
8	1.5	2.4	3.2	4.8	8.5
10	1.3	2.2	3.0	4.5	8.1
15	1.1	1.9	2.6	4.0	7.1
20	1.0	1.7	2.4	3.6	6.4
50	0.5	1.1	1.7	2.4	4.3
Approximate HVL thickness measured at high filtrations	.18	0.24	0.3	0.5	0.8
Radiation filter (mm of Al)	.5	.5	3.0	3.0	3.0

Primary protection-barrier requirements . . as shown on typical chart in NBS Handbook 50, for x-ray tube current of 10 ma at various potentials and at increasing distances from the tube

require primary protection barriers.

X-ray protection techniques are based on the recommendations of the International Commission on Radiological Protection and of the International Commission on Radiological Units. This group has proposed that the permissible exposure rate for X-rays is 0.30 roentgens (r) per week, measured in air. This exposure may be distributed uniformly over the working time in a week or may be obtained in larger short-time exposures, provided the total does not exceed 0.30 r in any one week. It should be noted that this is not a tolerance dose, because it is not known that the body can tolerate any radiation. However, at such exposure levels no ill effects to the individual have been revealed to date that indicate the need for revision to a lower level requirement. Thus protective barriers must be designed to limit exposure rates to within these recommendations.

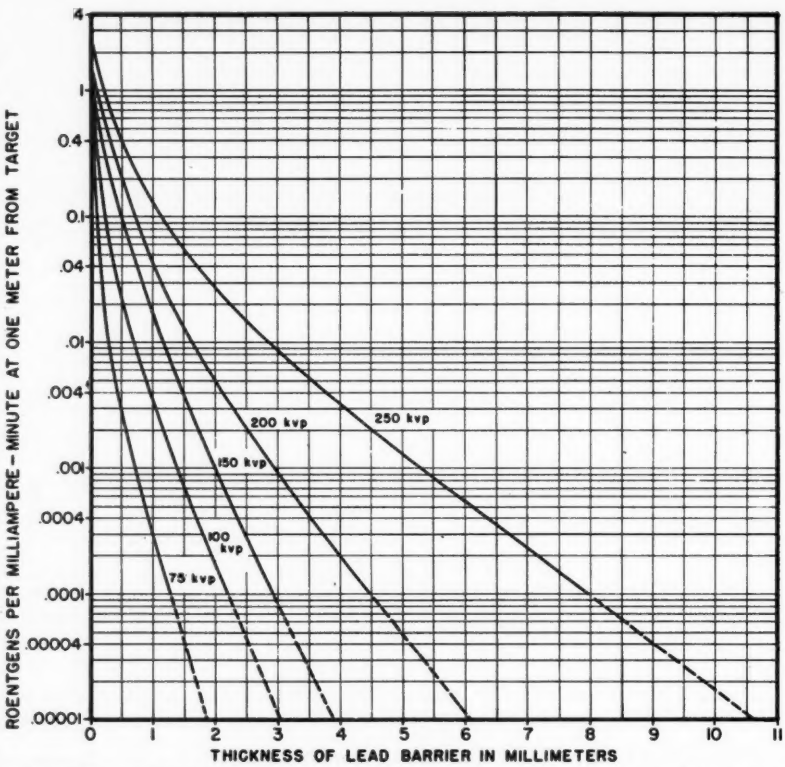
Four basic design principles . . must be included in every preliminary consideration of a new x-ray installation:

(1) The major portion of the protection should be as near to the x-ray tube as possible. It is usually recommended that a large amount of the protection be incorporated in the tube housing if this is compatible with the mechanical design requirements for mobility. This arrangement does not absolve the use of other barriers but does mean a marked reduction in the total volume to be required.

(2) It is desirable to restrict the direction of the useful beam. Only the area struck directly by the useful beam requires primary barrier protection; all other parts need only secondary protection. For instance, by restricting the direction of the useful beam toward the floor, the weight of doors may be reduced and the number of sheets of lead glass in observation and other windows may be decreased.

(3) It is usually considered advisable to compute all barrier-thickness requirements for a full 8-hour day. In spite of the fact that immediate requirements may dictate a thinner barrier, the cost of adding layers to existing protection (because the equipment is to be used for longer periods) far exceeds the expense of installing thick barriers during the initial construction.

(4) Lead is the major protective material in the low-voltage range and is also used in the high-voltage range when space is limited. Concrete, because of its structural strength, has been favored in the high-energy region where the absorption is principally a mass effect. In some isolated cases, where the voltages are very low, ordinary plaster walls may suffice for secondary barriers. In other instances, steel may be useful and economical for mobile barriers in low-potential installations and for doors in rooms housing high-voltage apparatus.



Typical curve showing attenuation in lead of x-rays . . produced by potentials of 75 to 250 kvp. Ordinate gives dosage rate of useful beam in **r** per min. 1 meter from target for 1 ma current

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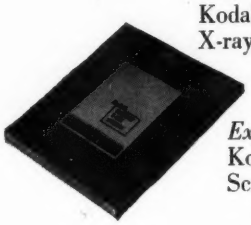

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Radiation attenuation curves . . and tables for the useful beam may be obtained from numerous experimental data which appear in the literature. The information is usually developed for a particular material, such as concrete or lead, and for various ranges of x-ray potentials.

In addition, a consideration is made of the voltage waveform, direction of the x-ray beam with respect to the electron beam, and the inherent filtration associated with the experiment in all cases for which this information is available. All of these factors are important and, when possible, should not be overlooked in the design of adequate yet economical protection.

Several tables are presented in Handbook 50, including tables of primary protection-barrier requirements for potentials of 75 to 250 kvp (kilovolts, peak), 400 kvp, 500 and 1000 kvp satisfied by various thicknesses of lead, and barrier requirements for potentials of 500, 1000, and 2000 kvp satisfied by concrete.

The ordinate of the curves included in the handbook gives the dose rate of the useful beam beyond the barrier in roentgens per minute at a point 1 meter from the target for a tube current of 1 ma. The abscissa is in terms of the thickness of the specified barrier material that reduces the dosage rate of the 1-ma beam shown by the ordinate.

Barrier requirements at other distances and radiation outputs are computed on the basis of the dose rate of 1 meter. If the tube current is increased above 1 ma, the barrier requirements will also be increased; if the distance between the tube and the point to be protected is increased, the barrier requirements will be decreased. Thus, the curves indicate directly the barrier thickness required to reduce the dose rate to the permissible value of 10^{-4}r/min for 1 ma at 1 meter from the target.

Type of operation performed . . by the apparatus is the most important consideration in the design of x-ray installations. Design recommendations are made accordingly. For instance, fluoroscopes are required to have a lead-glass barrier, so that if all other recommendations are followed, the treatment room will require only secondary barrier protection. Radiographic equipment normally does not have a self-contained primary protective barrier as do the fluoroscopic units, and thus requires protection for all walls and the floor. In addition, many units incorporate extreme flexibility of movement of the tube housing so that all of the protection must be the primary barrier type. The same conditions are generally true of units used in 250-kvp deep therapy, and because of the increased energy, more stringent recommendations are required.

Additional considerations must be made when using equipment for 1-million volt therapy. In this instance it is recommended that the treatment room be located in an isolated area which is supported sufficiently to withstand the weight of the equipment. Furthermore, the motion of the tube should be restricted so that the x-ray beam can be pointed only at the most distant points of occupied space and never toward adjoining rooms, above the horizontal, or toward the observation window.

Illustration . . of the design recommendations proposed by NBS, described in full detail in Handbook 50, is a 250-kvp deep therapy installation. At the time the equipment is supplied by the manufacturer, its x-ray beam may be pointed in any direction. Unless restrictions are placed on the mechanical motion of the tube, all walls, floor, and ceiling should be primary protective barriers. As the beam cannot be pointed at all of these walls for the full 48-hour week, it is worthwhile to consider the proportion of time each protective barrier may be struck by the useful beam.

If it is possible to obtain all treatment conditions without directing the beam toward any one given barrier, a mechanical restriction may be incorporated in the tube motion. This area then requires only a secondary protective barrier with a consequent reduction in the thickness of the material.

Even if no such restrictions are permissible, it may still be possible to limit the period the beam will be pointed toward the ceiling, for instance, to a maximum of one-eighth the total time the unit will be used. Under these conditions, the primary protective barrier thickness originally computed for the ceiling may be reduced by 3 HVL. (HVL, the half value layer, is defined as the thickness of a material required to reduce the emergent radiation to one-half the dose rate of the incident radiation). For design purposes it should be assumed that the machine will operate at its full rating of 250 kvp and 15 ma whenever used.

A typical room in which the equipment might be used is described as being about 18 feet long, 14 feet wide, and 9 feet high. A hallway borders one of the walls, which also includes an entranceway. Ideally, no windows would be in the outside walls as they may give inadequate shielding and would require protective baffles.

The control booth for the x-ray apparatus would be as far removed as possible from the x-ray tube. The degree of occupancy of all adjoining rooms must also be considered. It is further recommended that in designing the barriers, the x-ray units be considered to operate a 48-hour week. In some instances, it may be possible to restrict the motion of the tube to a comparatively small treatment area. This move could result in reduction from primary to secondary barrier protection for as many as two complete wall areas. However, no matter what the restriction on motion may be, the largest amount of protection is required for the floor of the treatment room. It is recommended that multiple layers of protection should be placed in a circle of 2 or 3 feet radius with its center directly below the x-ray tube target.

Safety factor . . It should be noted that the computations upon which the recommendations are based provide adequate protection in all cases; in fact, in some instances, they provide overprotection. In order to be on the safe side, and because of the somewhat limited data now available, protection was computed for a long work period (48 hr/wk), a large radiation field, the maximum permissible personnel exposure (0.30 r per week), and safe

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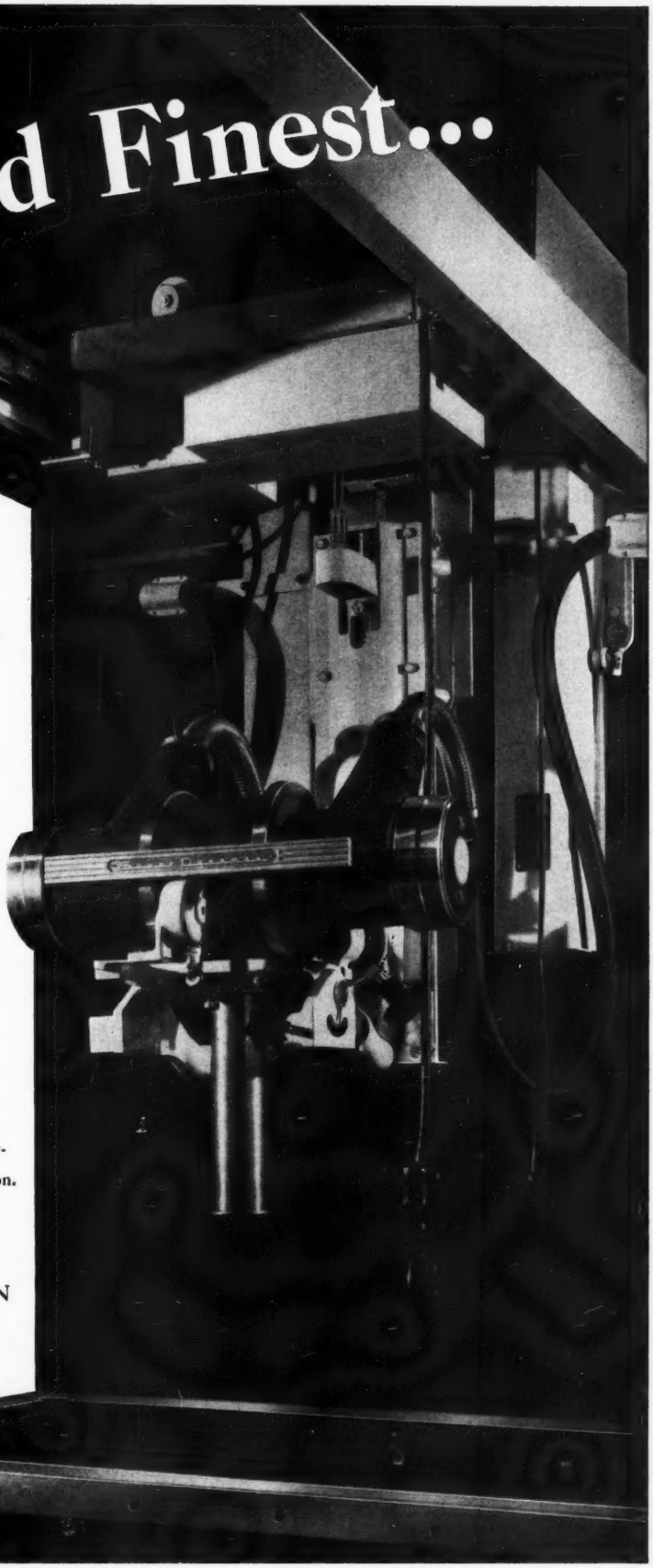

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REFERENCES

[1]*X-ray Protection Design,* by H. O. Wyckoff and L. S. Taylor, National Bureau of Standards Handbook 50 (May, 1952). For sale by the Superintendent of Documents, Washington 25, D. C. Price 15 cents.

[2]*Medical X-ray Protection up to Two Million Volts,* National Bureau of Standards Handbook 41 (March, 1949). For sale by the Superintendent of Documents, Washington 25, D. C. Price 20 cents.

Want to Finance a Hospital?

continued from page 4

pensing with the services of many on the medical staff.

Drs. Emanuel M. Almes, H. Leon Aussprung and Isaac H. Rigberg developed plans for a large Olney Doctors Hospital, which would admit these men. As constructed at Palmetto and Devereaux Sts., the streamlined hospital was staffed with a group of specialists covering all fields of medicine. Patients visiting the clinic could be examined by specialists in all branches to achieve the most benefit; in addition, doctors would be equipped to take care of their own patients and those referred to the hospital by other physicians.

"The hospital was designed with the community in mind," Dr. Aussprung explained. "Having a hospital right near home makes it easier for patients to visit their doctors and for doctors to visit patients' homes, and easier too for visitors to see hospitalized patients. It saves time for everyone who must get to the hospital, a most important factor, indeed, in emergency cases."

The three doctors who initiated the idea for the hospital are its principal stockholders and board of directors. Doctors associated with the hospital will be able to conduct their practices without interference from laymen directors. Emphasis on cancer research is planned, along with other research to advance medical progress.

In design, the hospital was built to incorporate a pleasant, homey atmosphere with the most modern diagnostic and treatment facilities. It is a two-story construction of modern design. The twenty semi-private bedrooms are decorated in pastels with limed oak furnishings and woodwork; bathrooms are tiled in colorful tones. The three operating rooms and emergency room are tiled, while both delivery rooms have terrazzo floors and shockproof lighting. Instead of an elevator between floors, a ramp was installed.

The entire hospital has acoustic ceilings, the most modern heating system, an emergency lighting system, public address system, and the latest clinical laboratory and x-ray equipment. Prior to its construction, the hospital . . as illustrated in its plans . . was approved by Blue Cross. ■

Let the Administrator Design

continued from page 36

above can be easily cited by practically any administrator in any part of the nation. It is not contended that there is a readily available answer to the problem. The point is many of these errors were avoidable and many can be avoided in the future. It seems that practically all new trustees when first appointed to the board almost immediately contact other boards and especially administrators in the area concerned. The burden lies on the administrators and functioning boards of trustees to give sound, reliable advice to the new hospital officials.

3. Given sufficient time administrator will do this

The writer believes that the administrators should make every effort to convince the new hospital officials that an administrator should be employed at the earliest possible time after the hospital project is actually approved.

By employing an administrator during the planning of the hospital, many advantages accrue to the community. The salary of the administrator will be repaid many times. The community will have a much better and more efficiently administered hospital. Actual operating costs can be lowered to some extent. Plans can be incorporated for the future by giving the administrator time to make economic and social surveys of the area involved. More and better equipment can be installed at the same anticipated cost. Rather than building the hospital to suit the fancy of a particular board or particular architect, the hospital can be made flexible enough that it can be efficiently operated by any group of officials. Sufficient time is allowed for the administrator to recruit and employ an efficient operating staff. Medical staff organization work will be facilitated by having sufficient time to give to this all important task. Public relations work can be carried on under circumstances favorable to the hospital. There will be no necessity to ignore the public in the last minute rush to open the hospital to meet an artificial deadline.

By all means the administrator should be allowed enough time to plan, organize, and staff the hospital. This means employment soon after the community or area decides to construct a hospital.

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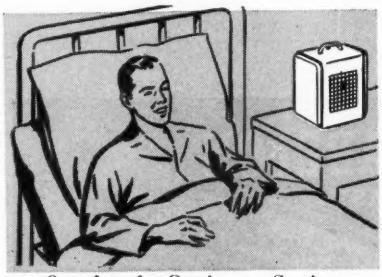

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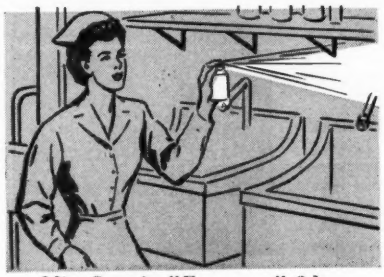

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Hospitals spend nearly 4 billion every 12 months

■ U. S. HOSPITALS totaled 6,832 in 1951, according to Dr. Edwin L. Crosby, president of the American Hospital Association, speaking before the Wisconsin Hospital Association at Milwaukee Feb. 19. These hospital plants are valued at $6,430,000,000. The hospitals have endowments of $8,210,000,000. Their annual expenses are $3,900,000,000. The rate per patient day in general community hospitals that year was $18.01, he continued, and 12 per cent of the people went to hospitals with 1,300,000,000 in hospitals now.

Dr. Crosby brought the group up to date of the plans of the association to set up a $5,000,000 institute of hospital affairs on the campus of and in cooperation with some university. The university would supply the personnel for hospital research while the institute would be the connecting link with hospitals.

The institute would work in four areas: management, plant design, professional practices, such as staffs, and community relations, such as the integration of rural and urban hospital services. It would seek the answers to such problems as how many graduate nurses a hospital should have in relation to aides and orderlies, or how large a dietary department it should have.

D. C. Reynolds, administrator, Madison General Hospital, Madison, Wis., told how the Madison Hospital Council had worked with the local department of public welfare to get adequate pay for indigent care. As it is now the department is billed like any other patient and 10 per cent subtracted.

George Bugbee, executive director of the American Hospital Association, commented on the importance of costs in today's hospital.

The state association's annual award of merit was made to Miss Grace T. Crafts, retired administrator of Madison General, who was cruising in the Carribean. Joe Norby, hospital consultant, accepted the award for her. Dr. H. M. Coon, superintendent of the University of Wisconsin Hospital, Madison, made the presentation. ■

Hospital buys property

■ BETH DAVID HOSPITAL of New York, now located on East 80th St., has purchased the plant of the Hospital for Special Surgeory on East 42d St., consisting of four- and five-story units on a plot running through the block on a frontage of about 200 feet, and a capacity of 235 beds. The Beth Israel Hospital will move to the property when the new plant of the Hospital for Special Surgery is completed on East River Drive between 70th and 71st streets sometime within two years. The purchase price was reported to be in the neighborhood of $2,000,000. ■

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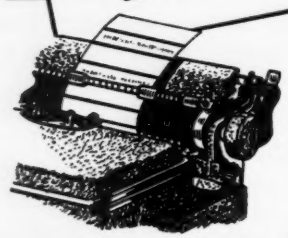

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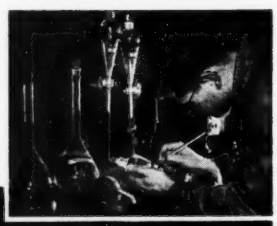

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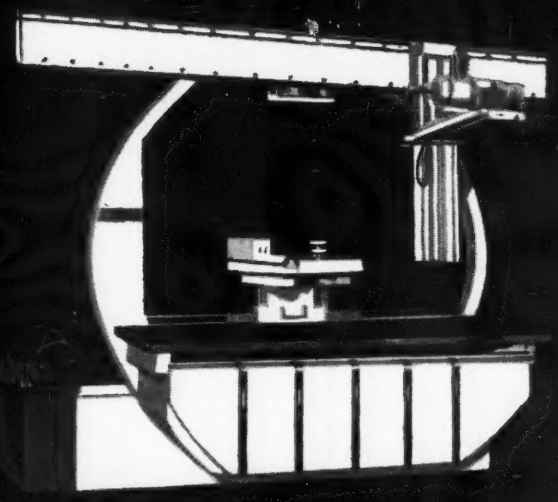

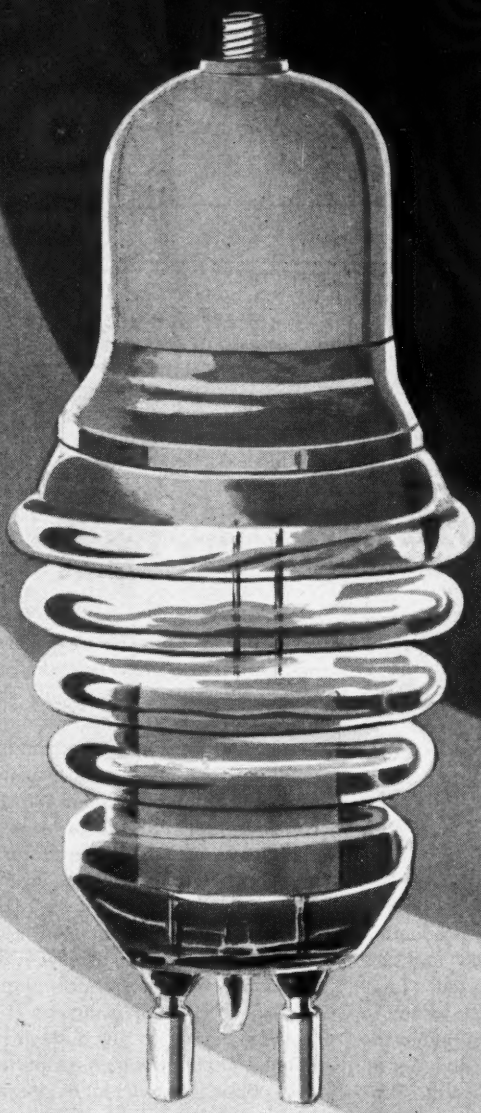

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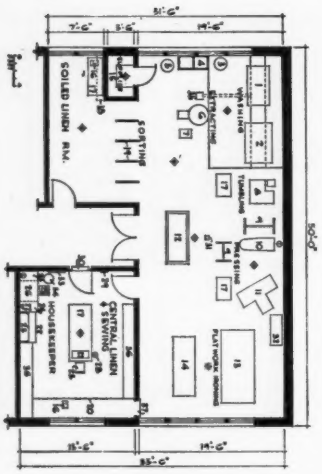
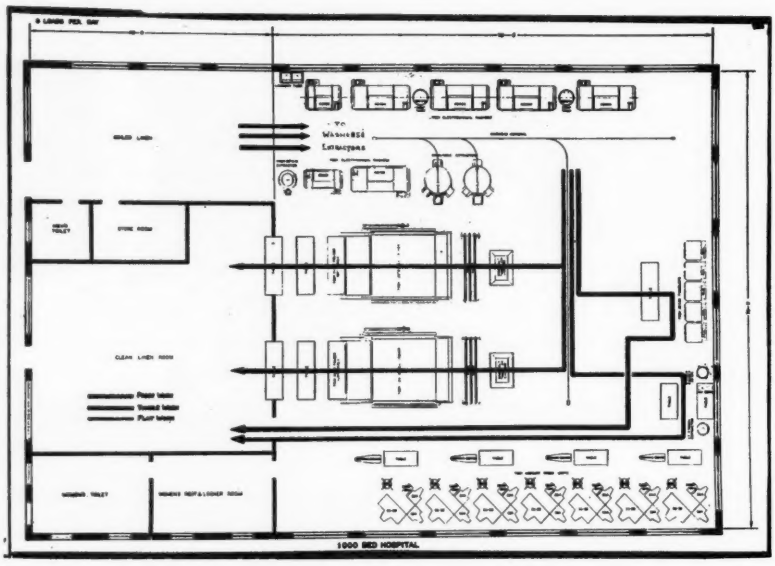


Whether it's a laundry for a 50-bed hospital . . .



. . . or a 1000-bed general hospital . . .

Strive For Balance of Plant and Staff in Laundry Layout

Templates and a schematic plan will aid you in visualizing how facilities should be placed for an even flow of work to operators

By H. S. ROHM
National Service Manager, Troy Laundry Machinery Division, Moline, Ill.

■ MODERN LAUNDRY MACHINES are better than ever and the better the equipment the greater the amount of thought and planning that must be devoted to insure the proper positioning of equipment. Thoughts on efficient plant layout are rightly focused on two distinct factors:

1. Placing the proper type of equipment in the correct place to insure high productivity.

2. The use of efficient methods to permit processing the work in the most effective manner.

Key to efficiency . . To maintain balance of plant and staff is one of the keys to the efficient operation of a hospital laundry and it is worth striving for. The path to production today must be made easy and this requires a good plant layout. Layout and equipment must permit a constant flow of work to enable the operators to keep busy and not to be short of work periodically. Production must be continuous and unrestricted, hour after hour, if low production costs are to be obtained.

It is almost futile, however, to try to get production in a plant which has not been planned and laid out for it. Efficient plants do not just happen; they require careful planning by your hospital laundry managers, who know best the problems peculiar to your plant. Your plant should be balanced, as there is no need to improve the efficiency of your flatwork crew if the washroom cannot keep work ahead of them. Keeping work ahead of each department is very important as workers often set their pace to suit a slower department.

The first requirement of a balanced plant is a smooth flow of work and this requires careful planning and an efficient plant layout.

Avoid trying to get by with outdated equipment which means valuable time wasted, high operating costs and aching backs. There is no economy in putting up with constant repairs and breakdowns.

Hospital laundries should be planned by competent laundry engineers assisted by the laundry manager. Consideration of individual hospital requirements in respect to

This paper was read Oct. 30, 1952 before the Institute of Hospital Laundry Management at Canadian Legion Memorial Hall, Regina, Sask.

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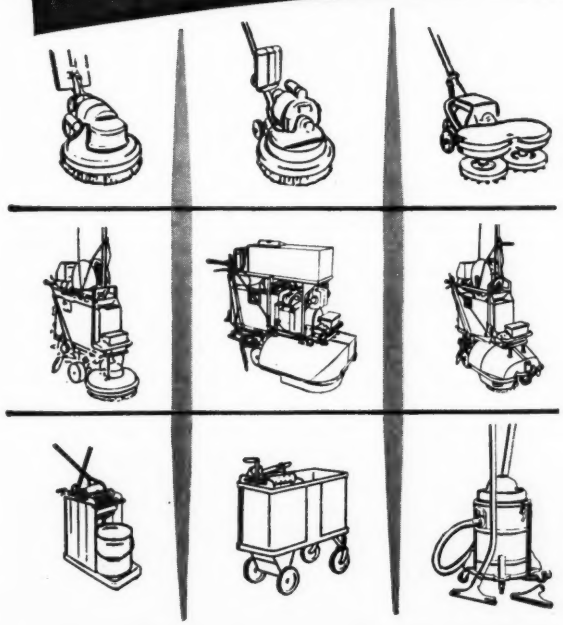

However much a maintenance man may want to do a good job, and at the same time show savings in labor costs, he's *stymied* if the machine is too small, or too large, or is otherwise unsuited to the job. Different floors and areas call for different care and equipment. That's why *Finnell makes more than a score of floor-maintenance machines.* From this complete line, it is possible to choose equipment that is correct in size as well as model . . . that provides the maximum brush coverage consistent with the area and arrangement of the floors.

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number of beds in the hospital, type of hospital, namely, general, maternity, tubercular or contagious diseases, is of prime importance. Only by efficient layout can laundries be constructed to best serve increasing hospital populations.

Lower cost production . . Laundries definitely will have to obtain greater production at lower cost in order to meet the higher wages and supply costs of today and, therefore, as laundry managers, do not be indifferent to this condition but resolve to do something about it by planning for efficient layout and production.

A study of the positioning of equipment in your plant offers an exceptional opportunity and will enable you to analyze the flow of work. Correct plant layout will insure maximum production from machines and each employee. . . Laundry machinery companies maintain large sales engineering departments who always are willing to work with you and prepare blue print plans.

Using a simple layout, a thorough study of your plant is desirable since many plants have a normal production well below what it might be and ought to be. Careful management and efficient operation will produce lower operating costs with less effort. Indifference to poor plant layout, obsolete and poorly maintained equipment, will do much to reduce interest and lower morale of your organization.

Schematic plant layout . . In planning a new laundry, or changes in an existing plant to improve efficiency or increase capacity of your laundry, the laundry manager should prepare a schematic plant layout or picture story to assist in visualizing the positioning of machines and flow of work for soiled to clean linen room. No special drafting skill is required to make a satisfactory plan.

To prepare this layout make an outline drawing of the laundry building to a scale of ¼ inch to the foot; show all doors, columns, elevators and any permanent objects which cannot be moved. Templates of paper or cardboard should then be cut out, to the same scale as the outline drawing, showing square foot area occupied by each piece of equipment. Templates can be square or rectangular. No fancy templates are required.

Position these templates correctly on the scale drawing of the laundry floor. They can be held in place by means of strips of scotch tape or rubber cement; either scotch tape or rubber cement will secure the templates temporarily so they can be shifted at will. Move the templates until the ideal arrangement is determined; then glue them permanently.

Then draw lines on the layout to indicate the flow of work. Different colored pencils will indicate the flow to various machines or processes. A careful study of this flow chart will quickly reveal any incorrect positioning of equipment.

Show your floor plan . . to supervisors, exceptional employees, other laundry managers or anyone whom you feel capable of making constructive criticism. Machinery companies maintain sales engineering departments who also will be glad to check your layout and make a final blueprint plan for you. We feel this schematic layout approach is the ideal means of arriving at an efficient laundry layout. There are few plants that a study as outlined would not improve.

In studying your schematic layout watch carefully for the following conditions:

1. Avoid back tracking and cross flow work. Flow should be as direct as possible from each department to the next. Straight flow will insure most efficient use of equipment with the least number of employees and result in economical operation.

2. Be sure sufficient space is allowed for soiled and clean linen storage.

3. Your flatwork ironer handles approximately 70 per cent of your finished work; sufficient working area must be allowed in front of the ironer for preparing the work and also at the receiving end of the ironer for handling finished linens.

4. Since the flatwork ironer handles 70 per cent of finished work, it should be located as near to the clean linen room as possible to reduce expensive transportation. Extractors should be located near the feed end of the ironer.

5. Whenever materials must be moved great distances, try and use mechanical means.

The schematic layout outlined is an excellent method of improving production in an existing plant or insuring correct flow of work in a contemplated new laundry. It is, moreover, a means of obtaining the maximum production from any plant.

Production costs . . are related directly to plant layout. The efficient layout will result in minimum handling, less transportation and good use of floor space. In talking to your help of proposed changes in the plant, do not stress cost savings but better working conditions. Obtain the confidence of your workers that changes are for their advantage as well as that of the hospital.

This is definitely a problem of management and much can be accomplished in this respect by enlisting the interest of your laundry staff in the problem of increased production. Correct layout will, however, insure more output, less production cost, better human relations and permit the institution to pay higher wages.

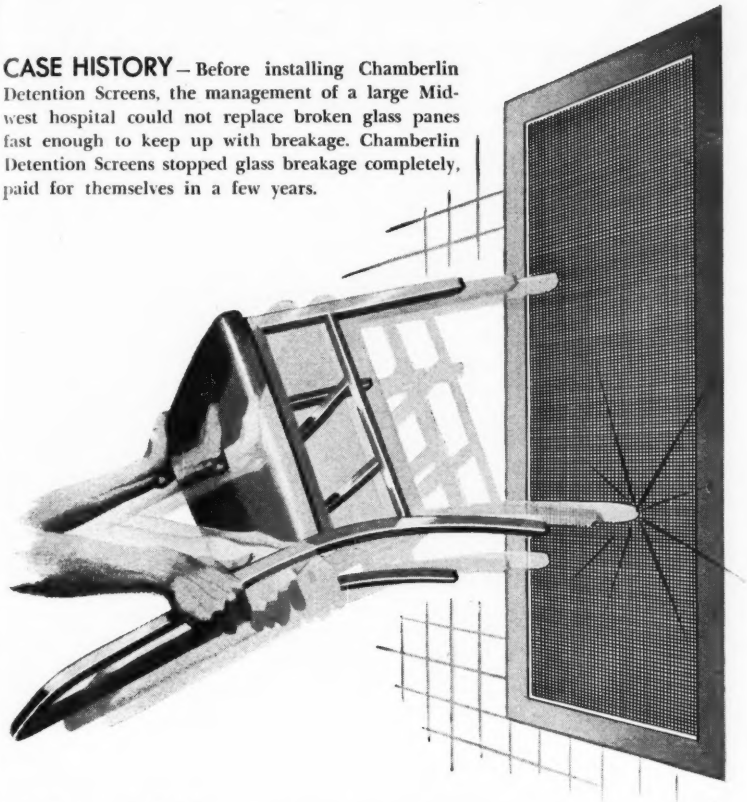
In revamping present plants, the cheapest way in the end may be the costliest. Inefficient plants generally result from placing new pieces of equipment in any space available without studying a flow chart.

Flow patterns . . New plants can be of the following types: straight through, circuit type or multi-floor type. In the straight through type the work enters at one end and leaves at the opposite end. The "U" flow laundry requires work to enter and leave at the same end of the laundry and we believe has possibilities for the best arrangement.

In multi-floor plants the work generally starts from the upper floors and progresses to the lower floors. Chutes can be used to advantage in this type of plant as in some laundries where work is dumped from unloading extractors into chutes on an upper floor to shakeout tables on a lower floor, directly at the ironers.

It is advisable to locate the wash-

CASE HISTORY – Before installing Chamberlin Detention Screens, the management of a large Midwest hospital could not replace broken glass panes fast enough to keep up with breakage. Chamberlin Detention Screens stopped glass breakage completely, paid for themselves in a few years.



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You reduce glass breakage. Inside installation of Chamberlin Security Screens reduces window glass breakage, cost of glass replacement, patient injury (see above).

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You reduce sash repair and paint costs. Chamberlin Security Screens installed at recommended distance from window prevent patients from mutilating window frames, sash, hardware, and paint.

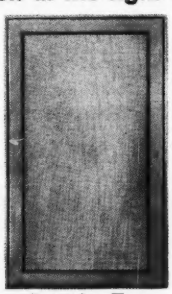
You reduce grounds maintenance costs. Chamberlin Security Screens prevent patient from throwing litter out of window, prevent outsiders from passing in forbidden objects.

You'll find from experience, as other hospital administrators have, that these savings more than offset the original cost of the screens. Yet they're only a few of many savings and services outlined at right.

Let our Hospital Advisory Service help you trim maintenance costs by recommending the type of Chamberlin Security Screens best suited to your needs. Write for information today.

The right screen at the right cost to fit your patients' needs

Detention Type



Protection Type

Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for non-violent patients.

QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings: Replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: Prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

Availability of metal products subject to defense regulations.

Modern institutions turn to

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CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, Calking, All-Metal Combination Windows, and Insect Screens

room near the power plant to reduce the cost of extensive piping. The washroom aisle should be eight feet wide and other aisles six feet. Do not put equipment against walls or so close together that machines cannot be lubricated or maintained. Insist on regular lubrication and inspection for repairs. Correct positioning of machines so that this is possible will reduce loss of time due to breakdowns.

Clean and soiled linen storage spaces require careful consideration and presents a specific problem for the manager of each individual hospital. Storage space also is necessary at the various laundry departments. Space should be available to take care of one hour's operation at each department. Do not allow too much space at various departments since this will require excessive transportation. Storage space requirements can be reduced by proper control and scheduling.

Selection of equipment . . The following are important reasons why revamping of laundry plants is desirable:

1. Replacement of undesirable equipment.
2. Plant out of balance.
3. High cost of operation.
4. Insufficient equipment.
5. Poor work flow.
6. Obsolete or inefficient equipment.

In selecting equipment the laundry manager must know the volume of work to be handled, division of work, that is, percentages of flatwork, tumbled work and press work. Standard division of work approximates 68 per cent flatwork, 25 per cent tumbled work and 7 per cent press work.

The amount of laundry used per patient day varies from 10 to 17 pounds for a general hospital. The average for general hospitals throughout the country is approximately 12 pounds per bed per day. The requirement for maternity hospitals is somewhat greater than the 12 pounds average; in T.B. hospitals the average is 5.5 pounds per bed per day. Veterans Administration figures are 7 pounds per bed per day for general and T.B. hospitals. Contagious disease hospitals very often use as high as 25 pounds per bed per day.

Many hospitals keep records of pieces processed and this does not seem to tell the story. Would it not be better to keep poundage records so that the amount of flatwork, tumbled or press work would be known? Poundage records would enable the laundry manager to quickly spot when and where inefficient operation was being experienced. How would you like to recommend equipment for a $100,000 laundry where the only data available is the number of pieces?

Equipment must not only be balanced with other equipment but also to the specific requirements of the hospital as related to special requirements and linen inventory. Under capacity in any one department results in inefficiency in the succeeding departments and each department should have a slight lead over the succeeding department.

In studying plant balance, consider machine capacities of machinery manufacturers and also the type of help that will be used to operate them. Inefficient help increases the amount of machinery required and in this respect operator training should be instituted. In the war period laundries did much more work than in peace time with no equipment replacements available, under great pressure and without trained help. So why not improve operation for normal times by improving plant layout and use of suitable equipment?

Design of building . . The design of a laundry building is the function of an architect. Some architects however have not previously designed laundries; they would welcome your help. Let them see your schematic layout or a machinery company's final blueprint layout.

The building should allow for reasonable expansion; excessive expansion allowance, however, will increase trucking of materials. Approximately 12 to 15 square feet of floor space will be required per bed. This will vary depending on the shape of the building and type of equipment used. Conveyors when actually required should be used. In new buildings a good plant layout, unless the hospital is very large, should not require conveyors. In revamping existing plants, conveyors will many times permit a good flow of work that otherwise might be impossible.

The following should be carefully considered in planning a new laundry: service mains of adequate size and as straight as possible, sufficient boiler capacity, suitable hot water heater and storage tank, water softener, heat reclaimer, adequate ceiling height, proper ventilation and lighting and location in respect to hospital. If there is a possibility that the laundry building will be increased in size, consideration should be given to providing for building expansion in the right direction.

Successful hospital laundry operation requires all-around efficiency. Neglect of the following essentials may materially limit possible savings to be made by improving plant layout or installation of modern machinery.

1. Water . . Water, the principal ingredient of any laundry formula, must be available quickly and in large quantities; three to five gallons per pound of linens, depending on type of soil and washers used, will be required. Many times complete new washrooms are purchased without considering the larger water inlets and outlets of modern washers which are furnished to reduce to a minimum the time required to fill and drain the washers. The large water inlets to the machines are of no advantage if small size water service main lines are not increased to furnish the volume of water required.

Fast dumping outlet valves are likewise handicapped by small pipes from the wash gutter. Inefficient pipe lines and water supply should be avoided.

2. Water softener . . One thousand grains of hard water will destroy one and one-half pounds of neutral soap. Therefore no cost reduction program can afford not to recognize the advantage to be gained by the use of a water softener of proper size and built to handle the rate of flow per minute

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• The new wing of the 310 bed Mary Fletcher Hospital in Burlington, Vermont, features the last word in modern kitchens. It was designed to provide a smooth flow of food from receiving through preparation and service. All food is prepared in the main kitchen which is equipped with the latest stainless steel specialized cooking tools: Blodgett Sectional Ovens for roasting and general oven cookery, steamers for vegetables, steam jacketed kettles for stock work, a broiler, deep-fat fryers and skeleton ranges (standard ranges with no ovens below.)

MODERN DESIGN SEPARATES RANGE TOP FROM OVEN COOKERY

The ultimate in hospital kitchen design is this main cooking bank. Note that the ranges have no ovens. All roasting and general oven cookery is done in separate Blodgett Sectional Gas-Fired Ovens. This unique feature eliminates the confusion that results when both oven and range-top cookery are done in the same unit.

Today's standard ranges with ovens are direct descendants of the old coal range wherein top and oven cookery were done in the same unit to get maximum use of fuel. With flexible gas fuel this concept is outmoded. Gas-Fired Sectional Ovens afford the kitchen designer means of removing the roasting oven from below the range top to provide a simplified and divided operation of general range top work and oven cookery. The four sections of Blodgett ovens have a capacity of twenty 25–35 pound turkeys, with similar capacity for other poultry and meats. Each section is equipped with an extra removable shelf to double the usable deck area. The ovens are also used extensively for quantity production of scrambled eggs, bacon, fish, baked and oven roasted potatoes, meat loaf, macaroni and cheese, escalloped and au gratin dishes, custards and a wide variety of puddings.

As in thousands of other hospitals throughout the country, the Mary Fletcher has found that Blodgett Sectional Ovens are truly their most useful and versatile cooking tool.

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Above: another section of the main cooking bank.

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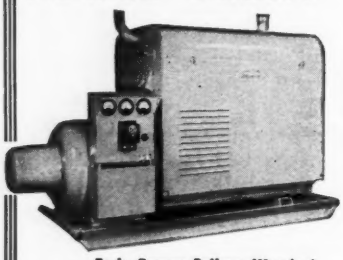

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required to quickly fill the washers.

A water softener will not only permit the use of a shorter washing formula but will completely eliminate the magnesium and calcium salts that form curds and build up on your wash wheel. Soft water will also reduce the amount of alkali and bleach required and with the shorter formula will definitely lengthen the life of your linens.

3. Heat reclaimers . . A modern laundry uses a large amount of hot water and, therefore, every effort must be made to reclaim heat units or BTU's wherever possible. Waste water from your washers is discharged to the gutter at the approximate average temperature of 115 degrees F. The installation of a heat reclaimer will save approximately 50 per cent of the heat units lost for your hot water supply. The reclaimer requires a pit approximately 6x12 feet below the floor level and between the gutter outlet and the sewer. Do not fail to investigate this possibility if you are not using a heat reclaimer.

4. Boiler . . Many times hospitals purchase new laundry equipment without first checking the increased load to be required of their already overloaded boiler. All laundry equipment is designed to be operated on steam at 100 pounds per square inch pressure for maximum efficiency. Any pressure less than 100 pounds will reduce the capacity of the equipment. Be sure your boiler will handle your laundry load and maintain 100 pounds pressure.

Steam supply lines and return lines should be of sufficient size. Overloaded steam supply and return lines seriously handicap laundry equipment. Steam traps on the return lines should also be of correct size and in good shape. Army camp laundries, where the boiler generally was a long way from the laundry, established the advantage of steam traps on the steam inlets directly at the ironer.

Do not expect super heated steam to improve operation of laundry equipment other than to make up for heat lost in transmission when the boiler is a long way from the laundry. A cubic foot of superheated steam actually contains less BTU or heat units per cubic foot than saturated steam at 100 pounds pressure.

Maintenance . . Good maintenance, or the art of avoiding breakdowns, will greatly reduce your loss of time and repair part expense. Make up lubrication charts and schedules and insist that they be followed. Good maintenance will generally locate trouble before it reaches a more serious stage. Keep cost records covering repairs to your equipment. Many times these will be helpful in deciding whether or not to replace a worn out piece of equipment. Possibly you are operating machines that require frequent and skilled maintenance that is not warranted by the actual labor savings the machines are supposed to effect.

Conclusions . . In conclusion it is recommended that you:

1. Keep production and cost records. Such records are very valuable and far outweigh their modest cost.

2. Resolve to make a schematic

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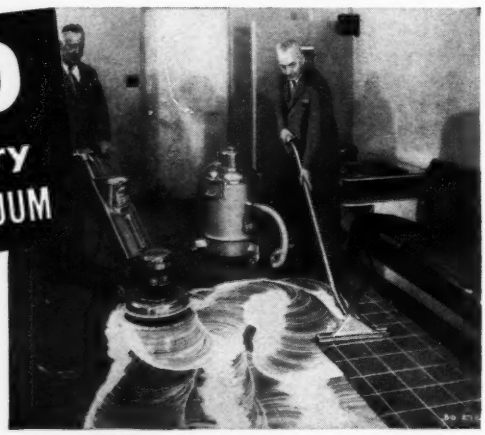

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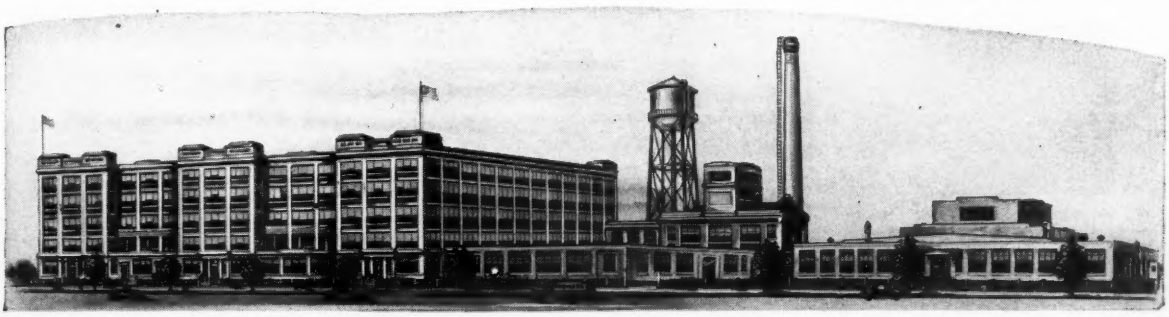
Thank you again for your support and insistence on quality of product.

Sincerely,

J. T. Gibbons

J. Thomas Gibbons
Vice President and
General Sales Manager



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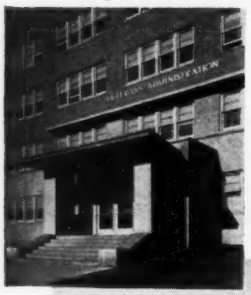

Veterans Administration Hospital, Chicago. Veterans Administration, Architects

St. Luke's Hospital, Davenport, Iowa. Schmidt, Garden & Erikson, Architects

For further information write Dept. H.

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layout of your plant and study it carefully. In many cases the indicated changes will simplify your work flow and reduce production cost.

3. A study of plant layout requires enthusiasm, and laundry managers as leaders should possess this quality and set the pace; without your enthusiasm for plant improvement hospital boards may not realize the possible savings and improvement in quality to be made. ■

Eliminate Noise

continued from page 39

acoustical unit, particularly the perforated tile, provides a material that meets most of the requirements in hospital construction. Perforated acoustical materials can be repainted with a reputable, high-grade paint in accordance with the manufacturer's approved recommendations, thereby providing practical maintenance at economical cost. When finished with enamel or comparable paint, perforated acoustical tile may be washed and cleaned in the same manner as a wall having a similar finish.

The prefabricated materials are, of course, manufactured to rigid specifications and have a known sound absorption capacity which cannot be impaired during application. The actual condition of any room can be accurately determined from the standpoint of "noisiness" or reverberation and after this analysis it is relatively easy to determine just how much absorption is necessary to obtain satisfactory results. As the appreciation of sound conditioning has grown the general trend has been to treat rooms a little more heavily than was common practice at the outset. A competent acoustical technician tries always to install just the right amount of material to give you the best possible results at the least cost. In short, there is a point where the installation of additional material brings into play the law of diminishing returns. The technician establishes this point, recommends accordingly.

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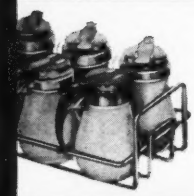

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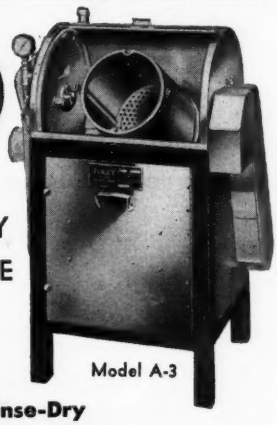

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Hospital can expect to be inspected more often under new program

Joint Commission adopts entire standards program of American College of Surgeons

■ HOSPITALS which have been wondering when they're going to be inspected for accreditation purposes eventually can expect a visit from inspectors at least every two years, perhaps more often. George Bugbee, executive director of the American Hospital Association, brought this word to the American Protestant Hospital Association at Chicago Feb. 13, speaking in the absence of Edwin L. Crosby, M.D., executive director of the Joint Commission on Hospital Accreditation.

Mr. Bugbee also brought word that the Joint Commission had adopted in its entirety the point rating system of the American College of Surgeons which was developed under the direction of Malcolm T. MacEachern, M.D., then director of the standardization work. Few changes are expected in the standardization program in the immediate future.

Some research is being done by the Commission on how often staff meetings should be held. While it has been suggested that monthly meetings be held the Commission is getting complaints from many physicians that this is too often.

Under Dr. Crosby's direction . . the Commission hopes to make hospital inspections a much more regular thing. An example was given of one hospital wondering if it was still on the approved list because it hadn't been inspected for 10 years.

A lot of field work remains to be done. The American Medical Association has 12 inspectors in the field. The American Hospital Association has taken over four inspectors which formerly examined hospitals for the American College of Surgeons. The College of Surgeons is especially interested in the examination of tumor clinics at this time.

The point was made that the development of a capable inspection staff takes time but it will be done. Assurance was given that the field staff will play a helpful role in advising hospitals on steps to take to assure accreditation.

Dr. Crosby was unable to be at

A. P. H. A. presidents . . Lee S. Lanpher, left, present president; C. E. Copeland, center, president-elect, and John G. Dudley, right, retiring president. (See page 124 for connections)

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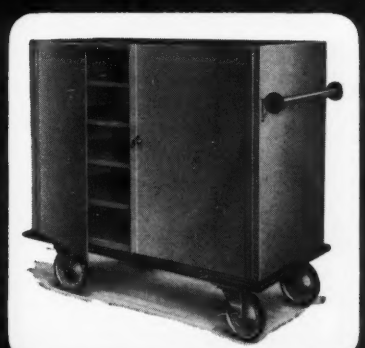

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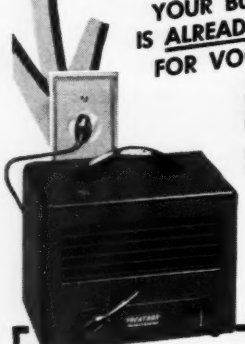

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STATE.....

the meeting because he was out of the city, engaged in the task of developing the accreditation program. This is a particularly busy year for him because he also is president of the American Hospital Association.

Mr. Lanpher is administrator of Lutheran Hospital, Cleveland, O.; Mr. Copeland is administrator of Missouri Baptist Hospital, St. Louis, and Mr. Dudley is administrator of Memorial Hospital, Houston, Texas.

Other officers are: first vice-president, Colonel Florence Turkington, Salvation Army, New York City; second vice-president, Hal G. Perrin, administrator, Bishop Clarkson Memorial Hospital, Omaha, Neb.

Leo M. Lyons, director, St. Luke's Hospital, Chicago, was elected a trustee replacing Mr. Perrin, for a term expiring in 1954.

Those elected trustees for terms expiring in 1956 are: Brigadier Alvena H. Wood, Wm. Booth Memorial Hospital, Covington, Ky.; Paul R. Hanson, Emanuel Hospital, Portland, Ore.; Edwin D. Peel, Georgia Baptist Hospital, Atlanta, Ga.; Crayton E. Mann, Welborn Memorial Hospital, Evansville, Ind.; Robert E. Neff, Methodist Hospital, Indianapolis, Ind.; and Mr. Dudley.

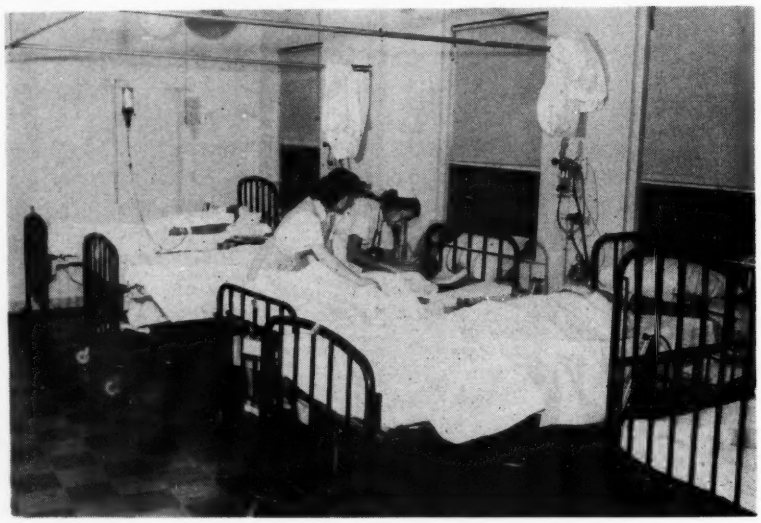
USPHS prepares new guide to head-nurse duties

■ THE PUBLIC HEALTH SERVICE, of the Federal Security Agency, announces publication of "The Head Nurse Looks at Her Job," a manual for studying head nurse activities in hospitals. The publication offers a method by which hospitals of all sizes may determine how head-nurse time is distributed between management duties and duties which could be performed by less skilled nursing personnel. Head nurses themselves have an opportunity to take part in the study and to analyze their own activities in comparison to functions generally accepted as appropriate to the head nurse job.

Prepared by Ruth I. Gillan, R.N., Helen G. Tibbitts, and Dorothy Sutherland, under the direction of Margaret G. Arnstein, R.N., chief of the Division of Nursing Resources, the manual reflects the Division's concern with finding ways of making more nursing care available to

continued on page 130

Modern recovery unit at University of Michigan



Special attention, special equipment . . for post-operative patients

■ SURGERY PATIENTS at the University of Michigan Hospital, Ann Arbor, are now taken to a special surgery recovery room to recover consciousness.

The newly-established facility provides such patients with closer supervision and more effective care. It has complete oxygen and respiratory suction equipment for ten patients, who are under the constant surveillance of a resident surgeon, a registered nurse and a nurse's aide. The room provides ample facilities for the hospital's daily average of 35 to 40 operations. ■

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An analysis of Audit Bureau of Circulations reports shows that Hospital Management has the largest hospital circulation ever achieved by any hospital publication at any time.

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two great Wyandotte dishwashing products

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Wyandotte SALUTE washes dishes better, cleaner, at less cost. It keeps china and plasticware stain-free. One soaking in concentrated solution clears already stained dishes. SALUTE is rapid-draining, prevents streaks, spots, keeps your machine free of scale and film.

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Two New PUTNAM Books for the Hospital Administration and Staff Members

PRINCIPLES OF HOSPITAL ADMINISTRATION
by John R. McGibony, M.D.

Brings together in concise form the best of administrative planning to serve the busy executive and members of his staff.

THIS HOSPITAL BUSINESS OF OURS
by Raymond P. Sloan
Foreword by George Bugbee

A book every board member should have immediately, since the author has specifically pointed out the trustee's authority. Be sure the members of your board are supplied with it at once.

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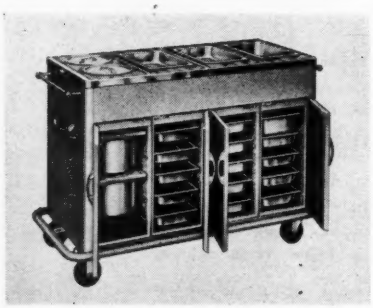
Product News | Literature



Portable food cart

■ WITH THIS NEW portable electric food cart a complete meal can be served to 200-300 people. Food stays hot while being delivered, and upon arrival extension cord may be plugged into outlet and food kept hot indefinitely. There are three insulated "hot" compartments, while salads and other "cool" foods may be refrigerated with ice or commercial cold-holding plates. Holds 18 service pans or 18 fireless cooker pots in hot section and 6 pans in cold section.

Circle 301 on mailing card for details.

New wireless intercom

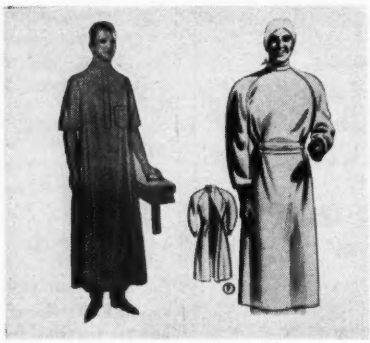
■ VOCATRON is a portable, "plug-in" intercom that requires no installation and no connecting wires; it uses the regular electric power and lighting circuits as its transmission medium. Can be used as public address system, for contact to patients rooms, for direct communication to any part of the hospital, etc. Silencing unit blanks out extraneous noises. Works on AC or DC, and is economical to use. Manufactured by Vocaline Co. of America.

Circle 302 on mailing card for details.

New type blood lancet

■ USED ONCE AND THROWN AWAY, Meinecke's new G-690 Disposable Blood Lancet eliminates all necessity for needle resterilization and resharpening, and greatly lessens danger of virus transmittal. Made of plated, rustless brass, the G-690 has a triangular head, flat blade and specially formed wedge point that excels in obtaining blood specimens. Tends to produce a slash wound, most desirable in blood specimen work. Handling has proved satisfactory with but little practice.

Circle 303 on mailing card for details.



Latest surgeon gown design

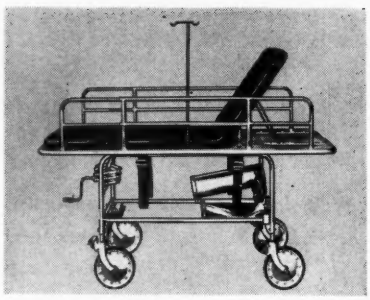
■ MANY YEARS OF research and testing are represented by the modern Angelica surgeon's gown pictured at right. Functional designing includes raglan sleeves for flexibility of movement and absorbent snug-fitting double stockinette cuffs. This gown is both comfortable and durable. At left is an old vintage gown which shows the progress made in surgeon gown design in the past 75 years.

Circle 304 on mailing card for details.

Thermoswitches guard plasma

■ A PAIR OF THERMOSWITCHES, precision thermostatic units manufactured by Fenwal Inc., function as temperature "watchmen" to prevent spoilage of blood plasma stored in the Jewett Refrigerator Company's hospital blood bank. An alarm bell in the thermostat circuit sounds when the internal temperature of the blood bank, nominally at 37F, reaches either 32F or 48F. The two thermostats provide instant alarm at the specified danger temperatures. The alarm rings until temperature is again within safe range.

Circle 305 on mailing card for details.



Oxygen tank holder available

■ HAUSTED MANUFACTURING CO. has introduced a new oxygen tank holder as optional equipment on the Hausted wheel stretchers. The standard stretcher, pictured here, is equipped for recovery room and post-anesthesia use. With the addition of the tank holder on the stretcher, oxygen can be administered while the patient is being transferred. Can be easily installed on all Hausted stretchers now in use in hospitals.

Circle 306 on mailing card for details.

New laboratory oven

■ LABLINE, INC. has on the market a new, low-priced laboratory oven. The oven has no heaters inside working chamber, bottom shelf can be completely loaded, special hydraulic thermostat with fully-enclosed "walking" contact points, special heat barrier and 3″ glass wool insulation, and a temperature range to 200°C. Two sizes available, with working chambers 13x13x13″ and 18x20x17½″.

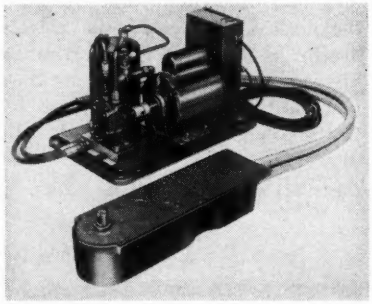
Circle 307 on mailing card for details.

Space problems solved

■ MILLS COMPANY'S movable walls can be used to permit immediate subdivision of wards or other hospital space, with a minimum of noise and disorder. These walls require practically no maintenance except ordinary washing, as they have a baked-on enamel finish. They are scientifically soundproofed and insulated. Units are easily installed

and are interchangeable. Ideal for institutions with space problems.

Circle 308 on mailing card for details.



Automatic door control is new

■ PRODUCTION of a newly designed, electrically operated hydraulic door control has been announced by Republic Industries, Inc. The automatic "Invisible Dor-Man" opens any type of door the instant a person steps on the carpet leading through the doorway. The door remains open until the person has passed through, and then closes with a two-speed action to insure noiseless operation. Can be used with any standard 110-volt, AC current. Can be operated manually in case of power failure.

Circle 309 on mailing card for details.

One-man fire engine

■ AMERICAN-LAFRANCE-FOAMITE CORP. has announced the manufacture of a one-man fire-fighting wheeled engine for extinguishing large-scale fires. It is a dry chemical engine with a capacity of 150 lbs. The expellent is dry nitrogen with a sustained operating pressure of 200 psi during the entire period of discharge. Has nozzle lever which permits opening or closing at will.

Circle 310 on mailing card for details.

Automatic sterilizer

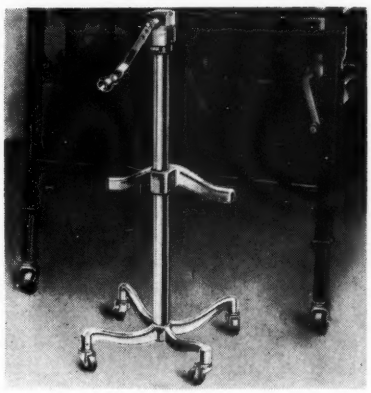
■ INSTRUMENTS are automatically soaked, scrubbed, sterilized, drained, and dried in 17 minutes in the new instrument washer-sterilizer manufactured by the Ohio Chemical & Surgical Equipment Co. Washer automatically heats water under pressure to a temperature of 270°. Dirt is washed away over a knife-edge overflow in the rear. Operates with direct steam heat, requires only two dial settings, operates on 115-volt, 60 cycle AC. Can be manually operated for high-speed instrument sterilization.

Circle 311 on mailing card for details.

Cooking, baking oil

■ KRAFT FOODS CO. announced recently that Kraft Oil for institutional use is now being distributed nationally. It will be sold in one and five gallon cans. During the product's introductory period Kraft is offering free, gallon-size samples of the oil to institutional users. Kraft claims that due to a special refining process, the oil is lighter-bodied and makes dressing and dough blending easier and faster. Can also be used for deep-fat, and pan and grill frying.

Circle 312 on mailing card for details.



Eliminates heavy lifting

■ THIS DE PUY improved bed lift works on a mechanical principal. Precision gears and a free turning handle make it easy for the nurse to raise a bed with a heavy patient. The jack is on swivel rollers for easy transfer. Once the bed is raised it may be put on blocks and the lift used elsewhere, or jack may remain until elevation is no longer needed.

Circle 313 on mailing card for details.

Tomac iceless oxygenaire

■ THIS IMPROVED OXYGEN tent control unit is completely automatic with no chance of mechanical breakdown. Condenses temperature rapidly, condensate evaporates automatically, and the unit is almost noiseless. Condensing unit keeps relative humidity in tent between 45 and 55 per cent. Possible oxygen concentration is 50 to 55 per cent at 12 liters flow. Has simplified control panel, easily installed canopy, stainless steel shelf and large storage compartment for supplies. Distributed by American Hospital Supply Corp.

Circle 314 on mailing card for details.

Emergency light

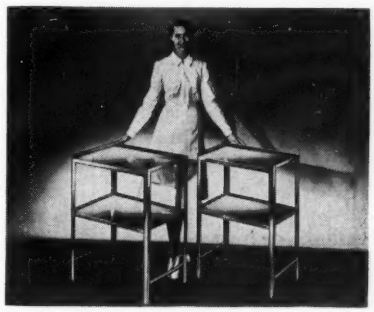
■ WHEREVER STORMS, fires, floods, accidents or a blown fuse disrupt lighting service, a Big Beam automatic emergency light provides illumination for hours. Operating on one standard 9-volt dry-cell battery, the unit provides 2½ hours of continuous light, dependable, automatic switch-over relay which operates both of the 6 inch adjustable flood light heads. Other features include a test switch for periodic check to determine if equipment is working, and Voltmeter with switch for testing battery. No special wiring necessary.

Circle 315 on mailing card for details.

Decorative floor coating

■ A NEW PROTECTIVE floor coating, which resists the alkali content of cement and cannot be softened by water, is being marketed by Flexrock Company. Does an excellent sealing job on practically any surface, is particularly good for use in laundries and washrooms, and is available in a variety of colors.

Circle 316 on mailing card for details.

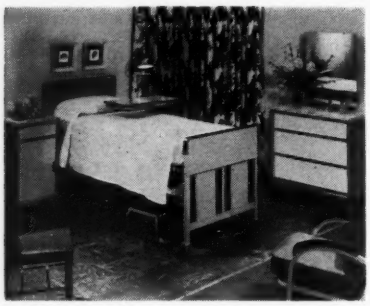


Space-saver tables

■ STAINLESS STEEL utility tables, for use in hospitals and other institutions, are now being produced by Lakeside Manufacturing Co. Can be used as stands for instruments, dressings, medicines, or as utility

tables in hospital rooms, kitchens, etc. These low-cost tables are made of all-stainless steel, and are available in two sizes.

Circle 317 on mailing card for details.



New concept in steel furniture

■ A COMPLETE NEW GROUP of Pictura hospital furniture is now available from the Simmons Co. Pictura furniture is available with durable steel tops or with self-banded Zalmite Tops that are burn, scratch, alcohol and mar proof. Absence of pulls makes cleaning easier and keeps maintenance costs at a minimum. Comes in all Simmons colors and grain finishes.

Circle 318 on mailing card for details.

Floor waxing simplified

■ THE MASTER-WAXER, product of Master Manufacturing Co., combines the application of wax and floor polishing into one easy operation. Flow of wax through lamb's wool head is controlled by ingenious finger-tip trigger built into the light weight aluminum handle. Manufacturer says Master-Waxer is ideal for dusting ceilings, mouldings, walls and hard to reach places. The detachable head is easily cleaned with warm soap and water.

Circle 319 on mailing card for details.

Imported microscope

■ AN IMPORTED microscope which can be used for any inspection operation, examination, dissecting, and various other uses, is being distributed by Edmund Scientific Corp., under the name of Edscope Stereo-Microscope. Unusual depth of focus and long length of working space render it ideal for working under magnification. The instrument is removable from base for remounting, has rack and pinion focusing, interpupillary adjustment, and is adjustable for extra height. Price is considerably less than other instruments of this type.

Circle 320 on mailing card for details.

Newly designed ice cube maker

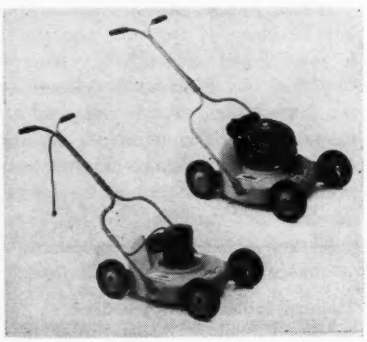
■ THE NEW AJAX ELECTRIC ICEMAN, which produces up to 350 lbs. of ice cubes daily, is now being marketed by the Ajax Corp. of America. According to the company, this new machine is an outstanding water saver, wasting less than 10 gallons of water during a 24-hour operation. After freezing, the cubes drop into an insulated waist-high storage bin for easy access. Requires less than one sq. yd. of floor space.

Circle 321 on mailing card for details.

Lighting fixture

■ THE GRUBER NO. T-580 offers direct and indirect light throw for general and/or local lighting over hospital beds. This wall mounted unit uses two 60-watt incandescent lamps in the upper section for general lighting and one 75-watt incandescent lamp in the lower section for local lighting on the bed. Eliminates necessity of overhead general lighting in hospital rooms. Manual control allows use of either the upper or lower or both sections of the fixture. Constructed of sturdy cast aluminum.

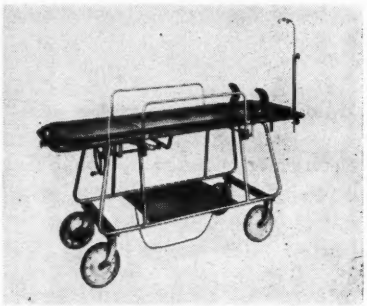
Circle 322 on mailing card for details.



Double duty mower

■ TWO NEW MOWERS, one powered by a gasoline engine and one electric motor driven, are being marketed by Sensation Mower, Inc. They are designed so that clippings are shredded so small they drop through the grass blades to the ground where they form a mulch and help retain moisture. Because the chassis is circular, the wheels are set so the blade is within range of grass along walls and fences, thus eliminating most hand trimming. Cutting height is adjustable on both mowers.

Circle 323 on mailing card for details.



Improved wheel stretcher

■ AMERICAN HOSPITAL SUPPLY CORP. announces the distribution of the Tomac wheel stretcher. Frame construction and wider wheel spread make tipping almost impossible. The platform below holds blankets and supplies, carriage has two wheel-brakes. Equipped with removable litter. Optional attachments include Trendelenberg Lift, shoulder braces, side rails, intravenous standard, and other conveniences.

Circle 324 on mailing card for details.

What can we do about this?

■ "I HAVE A HORROR of the hospital, that blend of penitentiary and third-class hotel," says Doctor Segrist in the book, *When Doctors Are Patients* edited by Max Pinner, M.D., and Benjamin F. Miller, M.D. "Of course, we need hospitals and we must be grateful that there are so many excellent ones . . The rooms are obviously made not to live in, but to be treated in; and even the flowers . . rather give . . the appearance of a funeral parlor. How much nicer it is to be sick at home, where we have our books, where the cat takes the place of a hot water bottle and where we may count on a decent cup of tea to the very end!"

News of Suppliers

Medical directors' group elects Dr. Rice

Dr. Justus B. Rice, director of medical research, Winthrop-Stearns, Inc., has been elected president of the Association of Medical Directors, a group comprising heads of the medical departments of approximately 40 U. S. pharmaceutical manufacturers. Election of officers, who will serve one-year terms, took place during the organization's monthly meeting held at the Advertising Club in New York City recently. Dr. Elmer Severinghaus, medical director of Hoffman-La-Roche, was named vice-president, while Dr. Norman Heminway of the Schering Corp. was reelected to the post of secretary-treasurer. Dr. Rice is an internationally recognized authority in the field of malaria and other tropical diseases.

50 years of progress celebrated by American

■ AS A PART OF ITS 50TH YEAR promotional activities The American Floor Surfacing Machine Company, Toledo, Ohio, is going to give away several hundred dollars worth of merchandise in prizes for the oldest American Machines in regular use the longest time. The contest, which is now open, will run throughout May 31, 1953, and awards will be announced during the month of July. All prizes, ranging from $500 down to $50, will be in merchandise manufactured by this company. American has prepared a portfolio of material which tells of its progress of the past 50 years.

Caleb Coffin, Squibb p.r. director dies

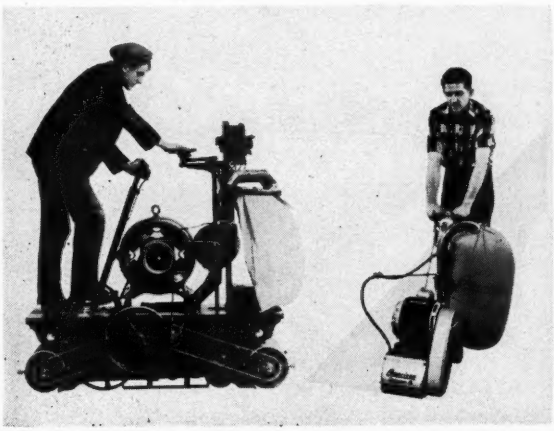
■ CALEB COFFIN, advertising manager and director of public relations of E. R. Squibb & Sons, New York, died at his home in the city on Jan. 15, after an illness of several months, at the age of 44. Mr. Coffin, a Princeton alumnus active in the activities of graduate Princetonians, was in the Air Force in England from 1943 to 1945, organizing and editing a report on "The Accomplishments of Air Power in the Defeat of Germany." He was awarded the Legion of Merit and the Bronze Star, returning to civilian life with the rank of lieutenant colonel. He became associated with the Squibb organization after the war, and rose rapidly to the important post indicated.

Other news . . The Multi-Clean Products, Inc., St. Paul, Minn., has completed negotiations for the purchase of the manufacturing facilities of the Industrial Vacuum Cleaner Department of the General Electric Co. The transaction includes all of the production dies, patterns, fixtures, and inventory.

B. A. Miller, general manager of the Magicolor Co., Chicago, Ill., has been appointed general sales manager in charge of sales of all divisions of Enterprise Paint Manufacturing Co. The position of sales manager of the Magicolor Co., which Mr. Miller held, in addition to his other duties, has been filled by Joseph Scher. He will coordinate sales and merchandising activities.

Expandex, the new plasma volume expander, manufactured by Commercial Solvents Corp., has been approved for commercial distribution. In view of this development, Max L. Miller, formerly with Squibb, has joined C.S.C. Pharmaceuticals as sales manager.

Stockholders will be asked to approve the terms of a merger involving Merck & Co., Inc., Rahway, N.J., and Sharp & Dohme, Inc., Philadelphia, pharmaceutical firms. The new company will be known as Merck & Co., Inc. ■



Big American . . pictured at left was first used over 50 years ago at Stanford University. American Super 8, at right, shows half a century of progress.

These students of Northwestern University . . enrolled in the hospital administration program, recently toured the Eli Lilly Research Laboratories, Indianapolis, Ind.

New Guide

continued from page 124

the public through the conservation and more effective use of scarce nursing skills.

Dr. Howard A. Rusk, chairman, Health Resources Advisory Committee, Office of Defense Mobilization, has contributed a foreword in which he says: "The use of this study method in a large number of hospitals across the country, followed by the necessary changes in organization, will be a long step forward toward improving nursing services in the most economical way."

The manual is in loose-leaf format and may be purchased at 40 cents per copy from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

New requirement for fire exists

■ DOORS leading to enclosed stairways in hospitals should now be marked "FIRE EXIT . . Please keep door closed." This requirement has been included in the new edition of the Building Exits Code, A9.1-1952, just approved as an American standard.

This new provision of the code is an attempt to solve one of the particularly troublesome problems in fire protection . . keeping stair doors shut so as to prevent the upward spread of fire and to safeguard the path of escape down the stairs.

The new code specifies the number, size, construction and position of exit facilities in order that buildings can be emptied promptly in case of fire, panic or other emergency. It recognizes that fire safety involves more than exits and accordingly also covers stairways, fire escapes, aisles and corridors, elevators, slide escapes, alarm systems, lighting and signs and fire drills.

A new requirement of the revised code is that doors be openable by a readily available, convenient and obvious type of latch.

Insurance companies, safety organizations, government agencies, fire protection groups, architects, technical and trade associations, and groups representing theaters, hospitals and hotels are represented on the American Standards Association committee which developed the building exits code.

Copies of the new code are available from the National Fire Protection Association, 60 Batterymarch Street, Boston 10, Mass., and from the American Standards Association, 70 East 45th Street, New York, N.Y., at one dollar each. ■

How to cut film on stainless steel

■ A STRAW COLORED FILM that forms over stainless steel equipment and other materials is caused by hard water and detergents, according to a recent report issued by Armco Steel Corporation. To correct this situation make a solution of 1 part Oakite No. 33 and 2 parts water. Use a stainless steel, enameled or glass container, and wear rubber gloves when applying the solution.

NEWEST OF THE NEW!

HORNER ANTI-SHRINK HOSPITAL BLANKET CUTS SHRINKAGE 83%

Repeated tests under average hospital laundry procedures prove that the revolutionary new Horner Anti-Shrink treatment process actually reduces blanket shrinkage as much as 83%. Yet, Horner Anti-Shrink Blankets retain their deep, soft nap, "warmth without weight" and original beauty after scores of launderings. They'll help you cut blanket maintenance and replacement costs to the very minimum!

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